DOCUMENT RESUME

ED 366 162 EC 302 765

AUTHOR Faller, Kathleen Coulborn
TITLE Child Sexual Abuse: Intervention and Treatment Issues. The User Manual Series.
INSTITUTION Circle, Inc., McLean, VA.; Westover Consultants, Inc., Washington, DC.
SPONS AGENCY National Center on Child Abuse and Neglect (DHHS/OHDS), Washington, D.C.
PUB DATE 93
CONTRACT S105-89-1730
NOTE 116p.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC05 Plus Postage.
DESCRIPTORS Caseworker Approach; *Child Abuse; Child Welfare; Criminals; Definitions; Incidence; *Intervention; *Interviews; *Investigations; Physical Examinations; Questioning Techniques; Reliability; *Sexual Abuse; *Symptoms (Individual Disorders); Victims of Crime

ABSTRACT

This manual describes professional practices in intervention and treatment of sexual abuse and discusses how to address the problems of sexually abused children and their families. It makes an assumption that the reader has basic information about sexual abuse. The discussion focuses primarily on the child's guardian as the abuser. The manual contains the following chapters: (1) "Working in the Field of Child Sexual Abuse," which discusses the professional as a person and elements of a victim-centered approach; (2) "Definitions, Scope, and Effects of Child Sexual Abuse," which provides clinical and statutory definitions, prevalence and incidence rates, and a review of the impact of abuse on its victims; (3) "Indicators of Child Sexual Abuse," which outlines medical and psychosocial indicators; (4) "Investigation of Child Sexual Abuse," which examines the role of child protective services, the medical examination, interviews, and risk assessment; (5) "Techniques for the Child Interview and a Methodology for Substantiating Sexual Abuse," which analyzes questioning techniques, use of anatomically explicit dolls, and research on the reliability and suggestibility of child witnesses; (6) "Treatment of Child Sexual Abuse," which describes case management considerations, causal models of sexual abuse, and treatment issues for the parties involved. The manual also provides a glossary, a 30-item bibliography, a list of organizational resources, and four evaluation protocols. (JDD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U S DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it
Minor changes have been made to improve reproduction quality
Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

ED 366 162

National Center on Child Abuse and Neglect

Child Sexual Abuse:
Intervention and Treatment Issues

The User Manual Series

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

BEST COPY AVAILABLE

Child Sexual Abuse: Intervention and Treatment Issues

Kathleen Coulborn Faller

1993

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

This manual was developed and produced by The Circle, Inc., McLean, VA, under subcontract No. S105-89-1730 to Westover Consultants, Inc.

TABLE OF CONTENTS

PREFACE vii

ACKNOWLEDGMENTS ix

WORKING IN THE FIELD OF CHILD SEXUAL ABUSE 1

The Professional as a Person 1
Universal Emotional Reactions 1
The Impact of Gender 2
The Impact of Socioeconomic and Professional Status 3
The Impact of Personal Experiences 4
Sexual Victimization 4
Being a Parent 4
Sexuality 5
Coping With Personal Issues 5
Dealing With Personal Feelings in Professional Practice 5
Avoiding Burnout 6
A Victim-Centered Approach 6
The Potential Iatrogenic Effects of Intervention 7
Strategies for Minimizing the Trauma of Investigation 7
Strategies for Ensuring That Intervention Is in the Victim's Best Interest 8

DEFINITIONS, SCOPE, AND EFFECTS OF CHILD SEXUAL ABUSE 9

Definitions 9
Statutory Definitions 9
Child Protection Definitions 9
Criminal Definitions 10
Clinical Definitions 10
Differentiating Abusive From Nonabusive Sexual Acts 10
Sexual Acts 11
Circumstances of Sexual Abuse 14
Scope of the Problem of Child Sexual Abuse 16
Prevalence of Child Sexual Abuse 16
The Incidence of Child Sexual Abuse 17
The Effects of Sexual Abuse on its Victims 18
What's Wrong About Sex Between Adults and Children? 18
The Impact of Sexual Abuse 18

INDICATORS OF CHILD SEXUAL ABUSE 21

Medical Indicators of Child Sexual Abuse 21
Two High-Probability Physical Indicators 22
Genital Findings 22
Anal Findings 24
Oral Findings 24
Psychosocial Indicators of Child Sexual Abuse 25
Sexual Indicators 25
Sexual Indicators Found in Younger Children 25
Sexual Indicators Found in Older Children 27
A High-Probability Sexual Indicator for All Children 27
Nonsexual Behavioral Indicators of Possible Sexual Abuse 27
Nonsexual Behavioral Indicators in Young Children 27
Nonsexual Behavioral Indicators in Older Children 28
Nonsexual Behavioral Indicators in All Children 28
Summary 29

INVESTIGATION OF CHILD SEXUAL ABUSE 31

The Role of CPS 31
The Structure of the Investigation 32
Gathering Information From the Referral Source 32
The Child Interview 32
The Medical Examination 33
The Interview With the Nonoffending Parent 34
The Interview With the Alleged Offender 35
Risk Assessment 37
Types of Emotional Risk 37
Factors To Consider in Risk Assessment 39

TECHNIQUES FOR THE CHILD INTERVIEW AND A METHODOLOGY FOR SUBSTANTIATING SEXUAL ABUSE 41

Introduction 41
Techniques for Interviewing the Child 41
Use of Questions 42
General Questions 42
Focused Questions 42
Multiple-Choice Questions 44
Yes-No Questions 45
Leading Questions 45
Strategic Use of Questions 45
Use of Anatomically Explicit Dolls 46
Challenges to Anatomically Explicit Dolls 46

Advantages of Anatomically Explicit Dolls 46
How To Use Anatomically Explicit Dolls 47
Use of Anatomical Drawings 49
Use of Picture Drawing 50
The Dollhouse 52
Research on the Reliability and Suggestibility of Child Witnesses 53
Children's Memories 53
Children's Suggestibility 53
Criteria To Be Used To Substantiate Sexual Abuse 53
A Description of the Sexual Abuse 54
Information About the Context of the Sexual Abuse 54
An Emotional Reaction Consistent With the Abuse Being Described 55
Situations In Which the Clinical Criteria May Not Be Found 55
Criteria for Confirming an Allegation From Other Sources 56
Suspect's Confession 56
Medical Evidence 57
Other Physical Evidence 57
Eyewitnesses 57
Forming a Conclusion About Sexual Abuse 57
TREATMENT OF CHILD SEXUAL ABUSE 59
Case Management Considerations 59
Should the Child Live With the Family? 60
The Role of the Courts 62
Visitation 63
Causal Models of Sexual Abuse 63
The Family-Focused Perspective 64
The Offender-Focused Perspective 64
An Integrated Model 64
Treatment Modalities 66
Treatment Issues 67
Treatment Issues for the Victim 67
Trust 68
Emotional Reactions to Sexual Abuse 68
Behavioral Reactions to Sexual Abuse 69
Cognitive Reactions to Sexual Abuse 70
Protection From Future Victimization 70
Treatment Issues for the Mother (Nonoffending Parent) 70
Issues Related to the Sexual Abuse 71
Issues Related to the Mother-Victim Relationship 71
Issues Related to the Offender (Spouse) 72
Other Personal Issues 73
Treatment Issues for the Father as the Offender 73

Issues Related to the Father's Past Sexual Abuse of Children 73
Issues Related to Possible Future Sexual Abuse 76

CONCLUSION 79

GLOSSARY OF TERMS 81

NOTES 83

SELECTED BIBLIOGRAPHY 91

OTHER RESOURCES 95

APPENDIX A: 97
Child Sexual Behavior Inventory

APPENDIX B: 101
Risk Assessment Protocol for Child Sexual Abuse

APPENDIX C: 107
A Continuum of Types of Questions To Be Used in Interviewing Children Alleged To Have Been Sexually Abused

APPENDIX D: 111
Guidelines for Determining the Likelihood Child Sexual Abuse Occurred

LIST OF CHARTS

CHART 1. Interview Data Gathered from the Mother 36

CHART 2. Interview Data Gathered from the Offender 38

CHART 3. Treatment Strategy Decision Matrix 61

CHART 4. Integrated Model of the Causal Factors of Sexual Abuse 65

PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social service, mental health, medical, educational, legal, and law enforcement resources to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts to achieve this goal, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the *User Manual Series*) to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. Some manuals described professional roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics, for example, adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were first developed. This increased knowledge has improved our ability to intervene effectively in the lives of troubled families. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles key professionals can play in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals. Finally, we are facing today new and more serious problems in families who maltreat their children. For example, there is a significant percentage of families known to Child Protective Services (CPS) who are experiencing substance abuse problems; the first reference to drug-exposed infants appeared in the literature in 1985.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the *User Manual Series* by revising many of the existing manuals and creating new manuals that address current innovations, concerns, and issues in the prevention and treatment of child maltreatment.

This manual is intended to address the needs of professionals who encounter child sexual abuse in the course of their work. It describes professional practices in sexual abuse and discusses "how to" address the problems of sexually abused children and their families. It is not designed for laypersons, and it makes an assumption that the reader has basic information about sexual abuse.

Professionals from a range of disciplines and with varying levels and types of training confront child sexual abuse in their work. This manual is designed to be useful to all of them. It should meet the needs of child protection workers, the front line staff mandated to investigate reports of child maltreatment. Legal professionals, including judges, guardians *ad litem*, prosecutors, family lawyers, and law enforcement personnel, should find the manual informative. It should be valuable to mental health personnel: social workers, psychologists, and psychiatrists, who have responsibilities for reporting, diagnosing, and treating child sexual abuse. Educators and health care professionals, including the full range of physicians likely to be asked to examine sexually abused children; nurses; and other medical specialists will also benefit from the material in the manual.

The manual cannot substitute for the discipline-specific training of the professions. Moreover, the manual does not cover all aspects of child sexual abuse in depth. Issues regarding substantiation and case management are explored in greater depth than treatment techniques and research. In addition, specialized legal and medical information regarding sexual abuse is not covered in this manual.

ACKNOWLEDGMENTS

Kathleen Coulborn Faller, Ph.D., A.C.S.W., is Professor of Social Work, Director of the Family Assessment Clinic, and Codirector of the Interdisciplinary Project on Child Abuse and Neglect at the University of Michigan. Since 1977 she has engaged in research, clinical work, teaching, training, and writing in the area of child sexual abuse. She is the author of three books—*Social Work With Abused and Neglected Children*, (The Free Press, 1981); *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management, and Treatment* (Columbia, 1988); and *Understanding Child Sexual Maltreatment* (Sage, 1990)—as well as numerous scholarly articles. She is a member of the International Society for the Prevention of Child Abuse and Neglect, the Child Welfare League of America, the American Humane Association, the National Association of Social Workers, and the American Professional Society on the Abuse of Children (APSAC). Presently, she is a member of the Board of Directors and Executive Committee of APSAC and serves as Secretary and Cochair of the Practice Guidelines Committee of APSAC.

The following were members of the Advisory Panel for Contract No. HHS-105-89-1730:

Nainan Thomas, Ph.D.
Child Welfare Division
Prince George's County
Department of Social Services
Hyattsville, MD

Shirley Davis
Child Development and Family
Guidance Center
St. Petersburg, FL

Michael Nunno
Family Life Development Center
Ithaca, NY

Peter Correia
University of Oklahoma
Tulsa, OK

Howard Davidson
American Bar Association
Washington, DC

Anthony Urquiza
University of California
Sacramento, CA

Janet Hutchinson
University of Pittsburgh
Pittsburgh, PA

Judee Filip
National Resource Center
Child Abuse and Neglect
Denver, CO

John Holton
Greater Chicago Council for
the National Committee for
the Prevention of Child Abuse
Chicago, IL

Sandra Hodge
Department of Human Services
Augusta, ME

Marsha K. Salus
Chair
User Manual Advisory Panel
Alexandria, VA

WORKING IN THE FIELD OF CHILD SEXUAL ABUSE

Emotional reactions to child sexual abuse* are to be expected and are normal. However, it is important to recognize them and to prevent them from impairing our professional judgment or interfering with our role performance. This chapter examines the following issues: universal emotional reactions to child sexual abuse, the impact of the professional's gender, the role of socioeconomic and professional status, the effect of personal experiences, and coping with personal issues. In addition, this chapter describes how to incorporate a victim-centered approach into our work when there are competing case concerns.

THE PROFESSIONAL AS A PERSON

Despite education and training, which specifies how to perform our professional roles, each of us has personal reactions to our work. Child sexual abuse probably arouses more personal reactions than many of the problems we encounter. Although these may become less intense over time, they do not disappear. Nevertheless, they should not be regarded as a sign of inadequate role performance. After all, if we had no emotional reaction to the plight of a sexually abused child or a father facing a life sentence in prison, something would be wrong with us.

Universal Emotional Reactions

Initially, the enormity of sexual abuse is likely to engender one of two opposing responses—disbelief or belief accompanied by an intense desire for retribution. Such responses can cloud the most important issues—concern for the child and the child's safety.

Disbelief has a lengthy history. When Freud proposed that the etiology of the hysteria he was treating in middle class Viennese women was to be found in childhood experiences of sexual abuse, his theory was roundly rejected as preposterous by his colleagues. Ultimately he retracted this theory because he simply could not believe that so many and such worthy men could have committed incest. The theory he proposed instead was one that put responsibility on the victim, who was regarded as fantasizing about having the sexual relationship with the paternal figure in question.[1 2 3] The implication was that the sexual relationship was desired by the child. For 50 years, professionals were comfortable with the belief that sexual abuse, particularly incest, was quite rare, and when it did occur, it quite likely was the consequence of the child's seductive behavior and was not particularly harmful.[4 5]

This position could not be sustained in the 1970's. The Child Abuse Prevention and Treatment Act required that States mandate professionals to report suspected child maltreatment, including child sexual abuse, in order to qualify for specific Federal funding. The result of this provision was a dramatic increase in the number of cases of sexual abuse reported. These referrals were investigated by child protective services (CPS) caseworkers and law enforcement personnel. As a rule, a believable account of sexual abuse was

---

* "Sexual abuse" in this manual refers generally to sexual acts involving a child and a person who is significantly older, usually an adult. However, the discussion in this manual focuses primarily on guardian, or person responsible for the child's welfare (see, Child Abuse Prevention and Treatment Act).

assumed to be true,[6 7] and reports of sexual abuse were substantiated at approximately the same rate as other types of child maltreatment.

However, very soon, new doubts emerged in what is now called the "backlash." Claims are being made—by those accused, their lawyers, and a small number of professionals who serve as experts on their behalf—that many accusations of sexual abuse are untrue. Although research indicates that false allegations are rare,[8] the credibility and integrity of children and the competence of professionals who believe them are being challenged. More problematic is the fact that the backlash gains its strength from well-meaning professionals and lay persons who have a great deal of difficulty believing that an adult could sexually abuse a child. In addition, among those individuals who acknowledge the possibility, there is the strong tendency to minimize its traumatic impact on the victim.

The tendency to disbelieve is reinforced by the troubling emotional reactions that many people have if they conclude that in fact the child has been sexually abused—a sense of anger or rage at the offender. Professionals may believe that the offender should be jailed or that emasculation is suitable punishment. On the other hand, often professionals experience anger and helplessness when a disbelieving family court judge gives custody of a child to an alleged offender or criminal prosecution is unsuccessful.

The rather universal tendencies to want to explain away or minimize the sexual abuse or to desire "a pound of flesh" are also reflected in reactions specific to gender, to socioeconomic and professional status, and to personal experiences, which are described below.

The Impact of Gender

The gender of the professional is likely to influence reactions to cases of child sexual abuse. The major issue is gender identification. The impact of gender identification is complex and varied. At a specific level, it causes the professional to see a person of the same sex, whether offender, victim, or mother of victim, as "like me." At a more general level, the professional may regard the behavior or circumstance of a person of the same sex as reflecting upon not only the professional, her/himself, but also upon others of the same sex. Gender identification can result in either greater empathy or greater rejection of the person of the same sex. On the other hand, the fact that the child, alleged offender, or mother is of the opposite sex may render the professional relatively impervious to the plight of that person.

When confronted with an accused man, a male professional may be more concerned about the impact of an allegation on the man and may have greater difficulty believing the allegation than a female professional. As well, a male professional might be either more understanding of a male offender because he appreciates gender-related temptations or more censorious because the violation of the taboo reflects on all men. A female professional may give much less thought to the circumstance of the accused man and concentrate on the females (i.e., the girl victim and her mother) and their circumstances.

In one possible scenario, a female professional may be more disbelieving of accusations against women than a male professional because, as a woman, she cannot imagine doing such a thing. However, when she concludes, for example, that a mother has sexually abused her children, she may be especially enraged because of her personal experience as a mother. Similarly, a female professional may have more empathy for the mother of a victim having to choose between her child and her husband, because she is or has been in a comparably dependent position with a man. Alternatively, she may perceive the woman who sides with her husband as a "traitor to her sex."

Both male and female professionals have empathy for victims. However, it is possible that gender identification causes each to be more sensitive when the victim is of his/her gender. This may be particularly

true for male professionals when boys are victims, since there is less knowledge about the impact on boys, and boy victims are less likely to share their feelings.[9] A male professional, because of his experience of having been a boy, may better appreciate the boy victim's trauma or, alternatively, have more difficulty accepting the boy's vulnerability to victimization.

Finally, professional reactions to sexual abuse may differ by gender because men and women experience living in society differently. That is, although men may not condone their position, they are generally dominant. Women are generally in the subservient position and are probably, as professionals, more appreciative than men of the relationship of sexual abuse to general male dominance in society.

The Impact of Socioeconomic and Professional Status

Professionals need to be aware that they may react differently to cases involving middle to upper class individuals and cases involving the poor. Moreover, situations in which the accused is in a sensitive profession may evoke personal reactions that make it especially difficult to maintain professional distance and act without bias. As with gender, the issue of identification and consequent disbelief may play an important role.

Most professionals working in sexual abuse identify themselves as middle class; thus, they may be more aware of the impact on a middle class person of being accused or found guilty of a sex offense. Class bias is reflected in a commonly held assumption that the trauma of being accused or getting caught is greater for someone who has had an economically successful life and a promising future. In addition, professionals may have more difficulty believing abuse of a middle class person because the accused is "like us."

Likewise, the middle or upper class person may seem less likely to be a sex offender because he/she functions well enough in other aspects of living to sustain class status and may deny more convincingly than someone who is poor and undereducated.

Moreover, the affluent accused who are denying are able to mobilize more resources on their behalf than poor people. They can afford competent lawyers and will have funds to hire mental health experts for their defense. They may enlist the assistance of professionals they know personally and professionally. They may have greater capacity to enlist family, including the wife or husband and others, who are financial dependents to support their claims of innocence.

Adding to the difficulty of impartial intervention, an economic argument may be made. It is that cases involving middle and upper class male offenders should be handled differently because, if the offender is arrested or tried, he will lose his job and not be able to support his family. If convicted, he won't be able to practice his profession any more. If he is incarcerated, he won't be able to pay his bills.

In addition, as professionals, we often experience pressure from the accused's advocates as well as from other professionals, including our superiors, to moderate our intervention when the alleged offender has means or is prominent in the community. Such experiences exacerbate existing ambivalence regarding our professional roles.

The most problematic cases are ones in which the alleged offender works with children or is a member of one of the professions that play a role in sexual abuse intervention—a health care professional, a lawyer, a judge, a law enforcement officer, a mental health practitioner, a day care provider, or a teacher. As professionals, we must be involved in the reporting, investigation, treatment, or prosecution of one of "our own." The psychological and pragmatic need to deny or to minimize the wrongdoing of one of "us" may be

especially strong. When faced with the knowledge of the sexual abuse, our ability to respond on a solely professional basis may fail.

Moreover, the stakes are extremely high because the accused professional almost certainly will not be able to continue to practice if found guilty. He/she knows this and therefore is very unlikely to admit to the sexual abuse or seek treatment. Because we as professionals can very easily imagine what it would be like to have our livelihood and well-being so jeopardized, we may become immobilized by denial or may perform our duty with great agony. Such responses reflect our overidentification professionally with the accused.

The Impact of Personal Experiences

Many life experiences can intrude upon professional practice, and working in sexual abuse can intrude upon a professional's personal life. Three personal issues that seem particularly salient are discussed below: having been sexually victimized, being a parent, and sexuality.

Sexual Victimization

A professional who has been sexually abused her/himself or who is part of a family in which there has been sexual abuse must cope with this personal issue as well as with the other stresses of work with sexual abuse. It is both infeasible and inappropriate to consider excluding such persons from working in this area. First, an estimated one-fourth to one-third of women are sexually victimized as children.[10 11 12] The current estimates for men are lower, around 10 per cent.[13] However, the majority of professionals who work in the field of sexual abuse are women. Second, persons who have sexual victimization in their background bring a special sensitivity and experience that can be of great value in their work. There is no research on professional motivation to work in sexual abuse. However, based on knowledge of what in general draws persons to help others, it is safe to assume that for a fair proportion of professionals, it has to do with some direct or personal knowledge about the problem.

Nevertheless, professionals who have personal experiences of sexual abuse need to have addressed these in therapy, be especially aware of countertransference issues, and be alert to the importance of protecting their own mental health.

Warning signs that the professional's own victimization is impeding performance include feeling so overwhelmed by fear, anxiety, disgust, or anger that the victimization interferes with sound decision making or intervention or evokes the strong desire for retribution; experiencing intrusive thoughts or having flashbacks at work; recalling previously repressed memories of victimization when involved in cases of sexual abuse; and displaying overly punitive responses to the nonoffending parent or offender. These signs certainly indicate the need for additional, skilled treatment and clinical supervision, but they should not automatically lead to a conclusion that the professional must cease her/his work in the field.

Being a Parent

The experience of parenthood can impact on one's reaction to a case of sexual abuse, and working with sexual abuse can influence parenting.

Parenthood can make the professional more appreciative of the risks as well as more appalled at the transgressions of the parenting role. Parents are confronted with many situations in which the child's behavior (e.g., wanting to sleep in the bed between the parents) and parenting responsibilities (the need to assist the child in bathing, toileting, and understanding differences between male and female anatomy) can present

risks for sexual activity. Sometimes, professionals who are parents are less willing to label client behaviors as sexually inappropriate because of their overidentification with the client as another parent. For example, a professional who is a father may minimize genital contact between an alleged offending father and his daughter, accepting the explanation that the daughter was being helped to learn about "wiping herself."

Conversely, certain biological drives and normative proscriptions inhibit sexual activity with children for parents. Because of these personal experiences, parents may be more censorious than nonparents when these boundaries are crossed.

In terms of work influencing parenting, a common impact of professional involvement with sexual abuse is for the parent to become quite concerned about the risk of his/her own child being sexually abused. Parents may become suspicious of family members, babysitters, friends of the family, neighbors, day care providers, and school personnel. Parents may also be hyperalert to behavioral and physical indicators, such as urinary tract infections, masturbation, enuresis, and sleep disturbances. Generally, vigilance about a child's contacts with others and concern about symptoms are positive parental responses. However, they should result in a considered investigation of suspicions, rather than an immediate conclusion that something terrible has happened.

Sexuality

Being familiar and comfortable with all aspects of sexuality is essential in working in the field of child sexual abuse. For the professional, this means being able to talk freely about all types of sexual issues.

Professional involvement with cases of sexual abuse very frequently has an impact on personal sexuality. There are at least three ways in which this occurs. First, when the professional engages in sexual activity, recollection of the sexual acts in a recent case may intrude into the sexual experience. Generally this has an inhibitory effect, that is, images of sexual activity or the particular sexual acts of the case diminish desire. However, a more troubling reaction is one in which the recollections stimulate arousal. They may become the stimulus for masturbatory activity or fantasies during sexual activity with a partner. When this happens, the professional should seek counseling.

Second, professional involvement in cases of sexual abuse may raise concerns about the professional's own sexual role performance. For example, men may wonder if they are subtly coercing or manipulating their partners. Women may become concerned that their compliance with sexual activity is not entirely voluntary, or they may worry that they are using sexual favors as a way of controlling their partners.

Third, professionals may have sexual reactions to their clients. Such reactions may be of attraction or disgust. In either case, professionals must be sensitive to these feelings and not let them influence professional responses.

Coping With Personal Issues

Dealing With Personal Feelings in Professional Practice

The best way to prevent personal reactions from undermining the quality of professional work is to be aware of their existence. In fact, the reason for describing possible sources of personal reactions and typical emotions is to encourage reflection by the reader. For many professionals, self-talk, in which the professional reminds him/herself of personal biases and reactions, should be undertaken regularly.

Second, as much as possible, the professional's intervention should be guided by practice principles, policies, guidelines, and research. For example, most communities have protocols for CPS and law enforcement collaboration. Similarly, there are practice guidelines for when to remove a sexually abused child from the home. Additionally, research on offender recidivism can assist a judge in sentencing. Nevertheless, despite the existence of these aids, because knowledge about sexual abuse is incomplete, there will be many situations in which the professional has to use his/her judgment. Sometimes, protocols and other guides actually interfere with gathering evidence or "proving" a case, engendering feelings of frustration and anger toward the system. In such instances, it is important for professionals to be able to process their feelings.

Avoiding Burnout

There is no denying that work in the field of sexual abuse is extremely stressful and may lead to burnout. There are four characteristics of cases that make the work potentially debilitating. First, the acts themselves are terrible and terribly harmful. Sexual abuse violates fundamental social norms, and the lives of some victims dramatically attest to its devastating effects. Second, cases are fraught with uncertainty. In many instances, it is not possible to determine whether the abuse occurred. Likewise, it is very difficult to determine the risk of future sexual abuse. Third, often as professionals, we do harm while attempting to do good. Victims are sometimes retraumatized by repeated interviews, intrusive medical exams, court testimony, and separation from their families. Fourth, often we are unsuccessful. Victims are not made safe, and offenders may not be prosecuted or held accountable for their actions.

Negative experiences working in the field of sexual abuse can result in frustration, rage, a sense of helplessness, and then giving up. A process of burnout eventually leads to insensitivity toward clients and disengagement in the helping relationship. Burnout is harmful for clients and professionals alike.

The best preventive measure and remedy for burnout is collaborative work. This can mean working with a partner, for example, as police officers often do. Having adequate supervision as a mental health professional is another way of working collaboratively. Sharing the treatment of an incestuous family with a colleague can prevent the sense of isolation and overwhelming responsibility that leads to burnout. Consulting with a more experienced person either within one's own agency or outside can be helpful in all professions. Interdisciplinary collaboration is also quite helpful—teams of CPS caseworkers and police or lawyers and mental health experts can enhance the quality of work as well as alleviate stress. Finally, working as part of a multidisciplinary team, which includes the range of professionals involved in child sexual abuse cases, is the most desirable way of handling these cases. Teamwork minimizes some of the problems that lead to burnout (e.g., the dilemma of uncertainty regarding whether the child was sexually abused, iatrogenic effects of intervention, and unsuccessful intervention). In addition, teamwork allows an opportunity for sharing the pain and distress that many cases cause professionals.

A VICTIM-CENTERED APPROACH

Professionals often feel pulled in several directions in their work on child sexual abuse cases. Although most professionals want to help the victim, potentially competing concerns include the feeling that sex offenders should be punished, a concern that the offender may be dangerous to others, a belief that sexual abuse is a mental health problem, a concern about the impact of disclosure upon the mother, a belief that the mother is partly responsible for the abuse, an awareness of the effect of sexual abuse and intervention on nonvictim siblings, and a feeling that everyone in the family needs help.

Taking a victim-centered approach is a way of dealing with conflicting goals in sexual abuse intervention. A victim-centered approach is one in which considerations of what is in the victim's best interest override competing concerns.

What is in the victim's best interest? That may vary depending on the case, and it may not always be easily discernible. Ascertaining the victim's best interest usually begins by finding out what the victim wants to happen, the older the child the more weight given to the victim's wishes. Does she want to be removed from the home or have the offender removed? Does she want the offender to be prosecuted or to get some help? Of course, there are times when what the victim wants is not in her best interest, because it risks her safety or psychological well-being. In such cases, the child's best interest should be pursued, but with a developmentally appropriate explanation to the child about why her wishes cannot be granted.

The Potential Iatrogenic Effects of Intervention

For some time professionals have been concerned with iatrogenic or system-induced trauma. One of the reasons that pursuit of the victim's best interest is so important is that a fundamental trauma resulting from sexual abuse is a sense of powerlessness. The victim's body is used by the offender for his gratification; the child is psychologically intimidated by the offender into cooperation with the sexual activity; and the child may be compelled by the offender to keep the sexual abuse a secret. Additionally, out of concern for the impact of disclosure on the family, the victim may feel forced not to disclose or that the consequences of disclosure may be worse than the abuse itself.

The complaint of many victims is that when the sexual abuse is discovered, things get worse rather than better because their lives continue to be controlled by others, and they experience all sorts of additional traumas. These may be repeated, insensitive, and humiliating interviews; a frightening medical exam; a confrontation involving the perpetrator or the victim's family; an unpleasant placement experience; treatment that the child finds unhelpful or traumatic; and court testimony. Often the most problematic aspects of intervention are not knowing what is going to happen and having no say in decisions. It is important that the intervention not exacerbate the child's sense of powerlessness.

Strategies for Minimizing the Trauma of Investigation

There are some fairly universally accepted strategies for diminishing the trauma of investigations of child sexual abuse. The interview process can be made less problematic. First, the number of interviews can be minimized, either by videotaping investigative interviews, having professionals who need to hear the child's account behind a one-way mirror, or having more than one professional in the room, usually with one asking the questions. Second, the use of a skilled and sensitive interviewer can minimize the negative effect of disclosure and even make it a cathartic or empowering experience. Third, allowing a support person to be with the child during part or all of the interview can diminish its traumatic impact. Fourth, conducting the interview in a facility that is private and designed to create comfort can be helpful. The potentially iatrogenic effects of the medical exam can be decreased by obtaining the child's consent to the exam and by using a skilled and sensitive health professional. That person explains that the purpose of the exam is to ensure that the child is "ok;" usually does a complete physical, not just a genital exam, and both informs the child, at each step of the exam, what will happen next and allows the child some control over the process. If the child is resistant to the exam, even when properly undertaken, then serious consideration should be given to not doing it. If it is deemed medically necessary, it might be rescheduled, when the child is less upset, or it might be done under anesthesia.

Children should not be subjected to polygraph exams during the course of investigation. Subjecting children to polygraphs gives the message that they are not to be believed and must "prove" themselves. The efficacy of polygraphs has not even been established for adults, let alone for children.[14]

Strategies for Ensuring That Intervention Is in the Victim's Best Interest

When an investigation substantiates child sexual abuse, professionals must decide what to do. Basic issues for the child are safety and rehabilitation. In addition, decisions about the use of the courts to protect the child and to prosecute the offender impinge heavily on the child's well-being. Related to these issues are questions about family separation. Does the family remain intact, does the offender leave, or is the child removed? Professionals agree that it is preferable to remove incest offenders from the home. However, there are cases in which, to protect the child, to prevent her/his psychological abuse, or to relieve the victim of the experience of family turmoil, the child needs to be placed outside the family. If the family has been separated, the question of family reunification has to be addressed.

There are two basic strategies that can enhance the probability that case decisions will be made in the child's best interest. The first has already been mentioned: the child should be asked what she/he wants. Second, case decisions should be preceded by a careful assessment and should be made in consultation with a multidisciplinary team, whenever feasible.

DEFINITIONS, SCOPE, AND EFFECTS OF CHILD SEXUAL ABUSE

DEFINITIONS

Most professionals are fairly certain they know what child sexual abuse is, and there is a fair amount of agreement about this. For example, today very few people would question the inclusion of sexual acts that do not involve penetration. Despite this level of consensus, it is important to define what sexual abuse is because there are variations in definitions across professional disciplines.

Child sexual abuse can be defined from legal and clinical perspectives. Both are important for appropriate and effective intervention. There is considerable overlap between these two types of definitions.

Statutory Definitions

There are two types of statutes in which definitions of sexual abuse can be found—child protection (civil) and criminal.

The purposes of these laws differ. Child protection statutes are concerned with sexual abuse as a condition from which children need to be protected. Thus, these laws include child sexual abuse as one of the forms of maltreatment that must be reported by designated professionals and investigated by child protection agencies. Courts may remove children from their homes in order to protect them from sexual abuse. Generally, child protection statutes apply only to situations in which offenders are the children's caretakers.

Criminal statutes prohibit certain sexual acts and specify the penalties. Generally, these laws include child sexual abuse as one of several sex crimes. Criminal statutes prohibit sex with a child, regardless of the adult's relationship to the child, although incest may be dealt with in a separate statute.

Definitions in child protection statutes are quite brief and often refer to State criminal laws for more elaborate definitions. In contrast, criminal statutes are frequently quite lengthy.

Child Protection Definitions

The Federal definition of child maltreatment is included in the Child Abuse Prevention and Treatment Act. Sexual abuse and exploitation is a subcategory of child abuse and neglect. The statute does not apply the maximum age of 18 for other types of maltreatment, but rather indicates that the age limit in the State law shall apply. Sexual abuse is further defined to include:

> "(A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the propose of producing a visual depiction of such conduct; or
>
> (B) the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children;..."[15]

In order for States to qualify for funds allocated by the Federal Government, they must have child protection systems that meet certain criteria, including a definition of child maltreatment specifying sexual abuse.

Criminal Definitions

With the exception of situations involving Native American children, crimes committed on Federal property, interstate transport of minors for sexual purposes, and the shipment or possession of child pornography, State criminal statutes regulate child sexual abuse. Generally, the definitions of sexual abuse found in criminal statutes are very detailed. The penalties vary depending on:

- the age of the child, crimes against younger children being regarded as worse;
- the level of force, force making the crime more severe;
- the relationship between victim and offender, an act against a relative or household member being considered more serious; and
- the type of sexual act, acts of penetration receiving longer sentences.

Often types of sexual abuse are classified in terms of their degree (of severity), first degree being the most serious and fourth degree the least, and class (of felony), a class A felony being more serious than a class B or C, etc.

Clinical Definitions

Although clinical definitions of sexual abuse are related to statutes, the guiding principle is whether the encounter has a traumatic impact on the child. Not all sexual encounters experienced by children do. Traumatic impact is generally affected by the meaning of the act(s) to the child, which may change as the child progresses through developmental stages. The sexual abuse may not be "traumatic" but still leave the child with cognitive distortions or problematic beliefs; that is, it is "ok" to touch others because it feels good.

Differentiating Abusive From Nonabusive Sexual Acts

There are three factors that are useful in clinically differentiating abusive from nonabusive acts—power differential; knowledge differential; and gratification differential.

These three factors are likely to be interrelated. However, the presence of any one of these factors should raise concerns that the sexual encounter was abusive.

- **Power differential**. The existence of a power differential implies that one party (the offender) controls the other (the victim) and that the sexual encounter is not mutually conceived and undertaken. Power can derive from the role relationship between offender and victim. For example, if the offender is the victim's father, the victim will usually feel obligated to do as the offender says. Similarly, persons in authority positions, such as a teacher, minister, or Boy Scout leader, are in roles that connote power. Thus, sexual activities between these individuals and their charges are abusive.

  Power can also derive from the larger size or more advanced capability of the offender, in which case the victim may be manipulated, physically intimidated, or forced to comply with the sexual activity. Power may also arise out of the offender's superior capability to psychologically manipulate the victim

(which in turn may be related to the offender's role or superior size). The offender may bribe, cajole, or trick the victim into cooperation.

- **Knowledge differential**. The act is considered abusive when one party (the offender) has a more sophisticated understanding of the significance and implications of the sexual encounter. Knowledge differential implies that the offender is either older, more developmentally advanced, or more intelligent than the victim. Generally, clinicians expect the offender to be at least 5 years older than the victim for the act to be deemed predatory. When the victim is an adolescent, some persons define the encounter as abusive only if the offender is at least 10 years older.[16] Thus, a consensual sexual relationship between a 15-year-old and a 22-year-old would not be regarded as abusive, if other case factors supported that conclusion.

  Generally, the younger the child, the less able she/he is to appreciate the meaning and potential consequences of a sexual relationship, especially one with an adult. Usually, the maximum age for the person to be considered a victim (as opposed to a participant) is 16 or 18, but some researchers have used an age cutoff of 13 for boy victims.[17] Apparently, the researchers felt that boys at age 13, perhaps unlike girls, were able to resist encounters with significantly older people and were, by then, involved in consensual sexual acts with significantly older people. However, clinicians report situations in which boys victimized after age 13 experience significant trauma from these sexual contacts.

  Situations in which retarded or emotionally disturbed persons participate in or are persuaded into sexual activity may well be exploitive, even though the victim is the same age or even older than the perpetrator.

- **Gratification differential**. Finally, in most but not all sexual victimization, the offender is attempting to sexually gratify him/herself. The goal of the encounter is not mutual sexual gratification, although perpetrators may attempt to arouse their victims because such a situations is arousing to them. Alternatively, they may delude themselves into believing that their goal is to sexually satisfy their victims. Nevertheless, the primary purpose of the sexual activity is to obtain gratification for the perpetrator.

  In this regard, some activities that involve children in which there is not a 5-year age differential may nevertheless be abusive. For example, an 11-year-old girl is instructed to fellate her 13-year-old brother. (This activity might also be abusive because there was a power differential between the two children based on his superior size.)

Sexual Acts

The sexual acts that will be described in this section are abusive clinically when the factors discussed in the previous section are present as the examples illustrate. The sexual acts will be listed in order of severity and intrusiveness, the least severe and intrusive being discussed first.

- **Noncontact acts**

  - Offender making sexual comments to the child.*

---

* When children are victims, sexual comments are usually made in person. However obscene remarks may be made on the telephone or in notes and letters.

- Example: A coach told a team member he had a fine body, and they should find a time to explore one another's bodies. He told the boy he has done this with other team members, and they had enjoyed it.

- Offender exposing intimate parts to the child, sometimes accompanied by masturbation.
  Example: A grandfather required that his 6-year-old granddaughter kneel in front of him and watch while he masturbated naked.

- Voyeurism (peeping).
  Example: A stepfather made a hole in the bathroom wall. He watched his stepdaughter when she was toileting (and instructed her to watch him).*

- Offender showing child pornographic materials, such as pictures, books, or movies.
  Example: Mother and father had their 6- and 8-year-old daughters accompany them to viewings of adult pornographic movies at a neighbor's house.

- Offender induces child to undress and/or masturbate self.
  Example: Neighbor paid a 13-year-old emotionally disturbed girl $5 to undress and parade naked in front of him.

- **Sexual contact**[**]

  - Offender touching the child's intimate parts (genitals, buttocks, breasts).
    Example: A father put his hand in his 4-year-old daughter's panties and fondled her vagina while the two of them watched "Sesame Street."

  - Offender inducing the child to touch his/her intimate parts.
    Example: A mother encouraged her 10-year-old son to fondle her breasts while they were in bed together.

  - Frottage (rubbing genitals against the victim's body or clothing).
    Example: A father, lying in bed, had his clothed daughter sit on him and play "ride the horse."

- **Digital or object penetration**

  - Offender placing finger(s) in child's vagina or anus.
    Example: A father used digital penetration with his daughter to "teach" her about sex.

  - Offender inducing child to place finger(s) in offender's vagina or anus.
    Example: An adolescent boy required a 10-year-old boy to put Vaseline on his finger and insert it into the adolescent's anus as initiation into a club.

---

* Activities in parenthesis are not illustrative of the sexual act being defined.

** Sexual contact can be either above or beneath clothing.

- Offender placing instrument in child's vagina or anus.
  Example: A psychotic mother placed a candle in her daughter's vagina.

- Offender inducing child to place instrument in offender's vagina or anus.
  Example: A babysitter had a 6-year-old boy penetrate her vaginally with a mop handle.

- **Oral sex***

  - Tongue kissing.
    Example: Several children who had attended the same day care center attempted to French kiss with their parents. They said that Miss Sally taught them to do this.

  - Breast sucking, kissing, licking, biting.
    Example: A mother required her 6-year-old daughter to suck her breasts (in the course of mutual genital fondling).**

  - Cunnilingus (licking, kissing, sucking, biting the vagina or placing the tongue in the vaginal opening).
    Example: A father's girlfriend who was high on cocaine made the father's son lick her vagina as she sat on the toilet.

  - Fellatio (licking, kissing, sucking, biting the penis).
    Example: An adolescent, who had been reading pornography, told his 7-year-old cousin to close her eyes and open her mouth. She did and he put his penis in her mouth.

  - Anilingus (licking, kissing the anal opening).
    Example: A mother overheard her son and a friend referring to their camp counselor as a "butt lick." The boys affirmed that the counselor had licked the anuses of two of their friends (and engaged in other sexual acts with them).*** An investigation substantiated this account.

- **Penile penetration**

  - Vaginal intercourse.
    Example: A 7-year-old girl was placed in foster care by her father because she was incorrigible. She was observed numerous times "humping" her stuffed animals. In therapy she revealed that her father "humped" her. There was medical evidence of vaginal penetration.

  - Anal intercourse.
    Example: Upon medical exam an 8-year-old boy was found to have evidence of chronic anal

---

* The offender may inflict oral sex upon the child or require the child to perform it on him/her or both.

** Activities in parentheses are not illustrative of the sexual act being defined.

*** Activities in parentheses are not illustrative of the sexual act being defined.

penetration. He reported that his father "put his dingdong in there" and allowed two of his friends to do likewise.

- Intercourse with animals.

Circumstances of Sexual Abuse

- Professionals need to be aware that sexual acts with children can occur in a variety of circumstances. In this section, dyads, group sex, sex rings, sexual exploitation, and ritual abuse will be discussed. These circumstances do not necessarily represent discrete and separate phenomena.

- **Dyadic sexual abuse**. The most common circumstance of sexual abuse is a dyadic relationship, that is, a situation involving one victim and one offender. Because dyadic sex is the prevalent mode for all kinds of sexual encounters, not merely abusive ones, it is not surprising that it is the most common.

- **Group sex**. Circumstances involving group sex are found as well. These may comprise several victims and a single perpetrator, several perpetrators and a single victim, or multiple victims and multiple offenders. Such configurations may be intrafamilial (e.g., in cases of polyincest) or extrafamilial. Examples of extrafamilial group victimization include some instances of sexual abuse in day care, in recreational programs, and in institutional care.

- **Sex rings**. Children are also abused in sex rings; often this is group sex. Sex rings generally are organized by pedophiles (persons whose primary sexual orientation is to children), so that they will have ready access to children for sexual purposes and, in some instances, for profit. Victims are bribed or seduced by the pedophile into becoming part of the ring, although he may also employ existing members of the ring as recruiters. Rings vary in their sophistication from situations involving a single offender, whose only motivation is sexual gratification, to very complex rings involving multiple offenders as well as children, child pornography, and prostitution.[18]

- **Sexual exploitation of children**. The use of children in pornography and for prostitution is yet another circumstance in which children may be sexually abused.

  - **Child pornography.** This is a Federal crime, and all States have laws against child pornography.[19] Pornography may be produced by family members, acquaintances of the children, or professionals. It may be for personal use, trading, or sale on either a small or large scale. It can also be used to instruct or entice new victims or to blackmail those in the pictures. Production may be national or international, as well as local, and the sale of pornography is potentially very lucrative. Because of the availability of video equipment and Polaroid cameras, pornography is quite easy to produce and difficult to track.

    Child pornography can involve only one child, sometimes in lewd and lascivious poses or engaging in masturbatory behavior; of children together engaging in sexual activity; or of children and adults in sexual activity.

    It is important to remember that pictures that are not pornographic and are not illegally obscene can be very arousing to a pedophile. For example, an apparently innocent picture of a naked child in the bathtub or even a clothed child in a pose can be used by a pedophile for arousal.[20]

- **Child prostitution**. This may be undertaken by parents, other relatives, acquaintances of the child, or persons who make their living pandering children. Older children, often runaways and/or children who have been previously sexually abused, may prostitute themselves independently.[21]

  Situations in which young children are prostituted are usually intrafamilial, although there are reports of child prostitution constituting one aspect of sexual abuse in some day care situations.[22] Adolescent prostitution is more likely to occur in a sex ring (as mentioned above), at the hand of a pimp, in a brothel, or with the child operating independently. Boys are more likely to be independent operators, and girls are more likely to be in involved in situations in which others control their contact with clients.[23]

- **Ritual abuse**. This is a circumstance of child sexual abuse that has only recently been identified, is only partially understood, and is quite controversial. The controversy arises out of problems in proving such cases and the difficulty some professionals have in believing in the existence of ritual abuse.[24]

  As best can be determined, ritual sexual abuse is abuse that occurs in the context of a belief system that, among other tenets, involves sex with children. These belief systems are probably quite variable. Some may be highly articulated, others "half-baked." Some ritual abuse appears to involve a version of satanism that supports sex with children. However, it is often difficult to discern how much of a role ideology plays. That is, the offenders may engage in "ritual" acts because they are sadistic, because they are sexually aroused by them, or because they want to prevent disclosure, not because the acts are supported by an ideology. Because very few of these offenders confess, their motivation is virtually unknown.

  Often sexual abuse plays a secondary role in the victimization in ritual abuse, physical and psychological abuse dominating. The following is a nonexhaustive list of characteristics that may be present in cases of ritual abuse:

  - costumes and robes: animal, witch's, devil's costumes; ecclesiastical robes (black, red, purple, white);
  - ceremonies: black masses, burials, weddings, sacrifices;
  - symbols: 666, inverted crosses, pentagrams, and inverted pentagrams;
  - artifacts: crosses, athames (daggers), skulls, candles, black draping, representations of Satan;
  - bodily excretions and fluids: blood, urine, feces, semen;
  - drugs, medicines, injections, potions;
  - fire;
  - chants and songs;
  - religious sites: churches, graveyards, graves, altars, coffins; and

- torture, tying, confinement, murder.

Most allegations of ritual abuse come from young children, reporting this type of abuse in day care, and from adults, who are often psychiatrically very disturbed and describe ritual abuse during their childhoods. Issues of credibility are raised with both groups. Moreover, accounts of ritual abuse are most disturbing, to both those recounting the abuse and those hearing it.

SCOPE OF THE PROBLEM OF CHILD SEXUAL ABUSE

Clinicians and researchers working in sexual abuse believe that the problem is underreported. This belief is based on assumptions about sexual taboos and on research on adults sexually abused as children, the overwhelming majority of whom state that they did not report their victimization at the time of its occurrence.[25] Moreover, it is probably true that situations involving female offenders as well as ones with boy victims are underidentified, in part because of societal perceptions about the gender of offenders and victims.

Estimates of the extent of sexual abuse come from three main sources—research on adults, who recount their experiences of sexual victimization as children; annual summaries of the accumulated reports of sexual abuse filed with child protection agencies; and two federally funded studies of child maltreatment entitled the *National Incidence Studies*. In addition, anecdotal information is supplied by some convicted/self-acknowledged offenders, who report sexually abusing scores and even hundreds of children before their arrest.

Prevalence of Child Sexual Abuse

Studies of the prevalence of sexual abuse are those involving adults that explore the extent to which persons experience sexual victimization during their childhoods. Findings are somewhat inconsistent for several reasons. First, data are gathered using a variety of methodologies: telephone interviews, face-to-face interviews, and written communications (i.e., questionnaires). Second, a study may focus entirely on sexual abuse, or sexual abuse may be one of many issues covered. Third, some studies are of special populations, such as psychiatric patients, incarcerated sex offenders, and college students, whereas others are surveys of the general population. Finally, the definition of sexual abuse varies from study to study. Dimensions on which definitions may differ are maximum age for a victim, the age difference required between victim and offender, whether or not noncontact acts are included, and whether the act is unwanted.

The factors just mentioned have the following effects on rates of sexual abuse reported. Face-to-face interviews, particularly when the interviewer and interviewee are matched on sex and race, and multiple questions about sexual abuse may result in higher rates of disclosure.[26] However, it cannot be definitively stated that special populations such as prostitutes, drug addicts, or psychiatric populations have higher rates of sexual victimization than the general population, because some studies of the general population report quite high rates.[27,28] Not surprisingly, when the definition is broader (e.g., inclusion of noncontact behaviors and "wanted" sexual acts) the rates go up.

Rates of victimization for females range from 6 to 62 percent,[29] with most professionals estimating that between one in three and one in four women are sexually abused in some way during their childhoods. The rates for men are somewhat lower, ranging from 3 to 24 percent,[30] with most professionals believing that 1 in 10 men and perhaps as many as 1 in 6 are sexually abused as children. As noted earlier, many believe that male victimization is more underreported than female, in part because of societal failure to identify the behavior as abusive. However, the boy himself may not define the behavior as sexual victimization but as sexual experience, especially if it involves a woman offender. Moreover, he may be less likely to disclose than a female victim, because he has been socialized not to talk about his problems. This reticence may be

increased if the offender is a male, for he must overcome two taboos, having been the object of a sexual encounter with an adult and a male. Finally, he may not be as readily believed as a female victim.[31]

The Incidence of Child Sexual Abuse

Incidence of a problem is defined as the number of reports during a given time frame, yearly in the case of sexual abuse. From 1976 to 1986, data were available on the number of sexual abuse cases reported per year to child protection agencies, as part of data collection on all types of maltreatment. These cases were registered with the National Center on Child Abuse and Neglect, and data were analyzed by the American Humane Association. Over that 10-year period, there was a dramatic increase in the number of reports of sexual abuse and in the proportion of all maltreatment cases represented by sexual abuse. In 1976, the number of sexual abuse cases was 6,000, which represented a rate of 0.86 per 10,000 children in the United States. By 1986, the number of reported cases was 132,000, a rate of 20.89 per 10,000 children. This represents a 22-fold increase. Moreover, whereas in 1976 sexual abuse cases were only 3 percent of all reports, by 1986, they comprised 15 percent of reports.[32]

Striking though these findings may be, their limitations must be appreciated. First, current data are not available. Second, cases included in this data set are limited to those that would warrant a CPS referral, generally cases in which the abuser is a caretaker or in which a caretaker fails to protect a child from sexual abuse. Thus, cases involving an extrafamilial abuser and a protective parent are not included. Third, the data only refer to reported cases. This means those cases that are unknown to professionals and those known but not reported are not included. Moreover, these are reports, not substantiations of sexual abuse. The national average substantiation rate is generally between 40 and 50 percent. Substantiation rates vary from State to State and among locations.

The National Incidence Studies (NIS-1 and NIS-2) provide additional data on the rates of child maltreatment, including sexual abuse. Information for these studies was collected in 1980 and 1986; thus, they do not provide annual incidence rates, as the Child Protection data do. In addition, these studies project a national rate of child maltreatment based on information from 29 counties, rather than using reports from all States. Nevertheless, these studies do allow for some analysis of trends because data were collected at two different time points. Moreover, one of the most important features of the NIS studies is that they gathered information on unreported as well as reported cases.

Differences between the first and second studies indicate there was a more than threefold increase in the number of identified cases of sexual maltreatment.* An estimated 42,900 cases were identified by professionals in 1980 compared with 133,600 cases in 1986. These figures represent a rate of 7 cases per 10,000 children in 1980 and 21 cases per 10,000 in 1986.[33] Despite the fact that the 1986 number and rate are quite close to the figures for suspected sexual abuse reported to child protection agencies in 1986, only about 51 percent of cases identified by professionals in the National Incidence Study were reported to child protective services (CPS). Furthermore, the proportion of cases identified but not reported to CPS did not change significantly between 1980 and 1986.[34]

---

* These statistics from the revised second National Incidence Study reflect the revised definition of child abuse and neglect, which includes the combined total children who were demonstrably harmed and threatened with harm.

It is clear that available statistics on the prevalence and incidence of sexual abuse do not completely reflect the extent of the problem. However, they do provide a definite indication that the problem of sexual victimization is a significant one that deserves our attention and intervention.

THE EFFECTS OF SEXUAL ABUSE ON ITS VICTIMS

Concern about sexual abuse derives from more than merely the fact that it violates taboos and statutes. It comes principally from an appreciation of its effects on victims. In this section, the philosophical issue of why society is concerned about sexual abuse and documented effects will be discussed.

What's Wrong About Sex Between Adults and Children?

It is important for professionals, particularly if they dedicate a substantial part of their careers to intervening in sexual abuse situations, to distance themselves from their visceral reactions of disgust and outrage and rationally consider why sex between children and adults is so objectionable.

Organizations such as the North American Man Boy Love Association (NAMBLA) and the René Guyon Society challenge the assertion that sexual abuse is bad because of its effects on children. These organizations argue that what we label as harmful effects are not the effects of sexual abuse but the effects of societal condemnation of the behavior. Thus, children feel guilty about their involvement, suffer from "damaged goods syndrome,"[35] have low self-esteem, are depressed and suicidal, and experience helpless rage because society has stigmatized sex between adults and children. If society would cease to condemn the behavior, then children could enjoy guilt-free sexual encounters with adults. Such organizations also argue that we, as adults, are interfering with children's rights, specifically their right to control their own bodies and their sexual freedom, by making sex between children and adults unacceptable and illegal.

How can we respond to this argument? It is true that many of the effects of sexual abuse at least indirectly derive from how society views the activity. However, the impact also reflects the experience itself. The reader will recall the earlier discussion of differentiating abusive from nonabusive encounters on the basis of power, knowledge, and gratification.

Because the adult has more power, he/she has the capacity to impose the sexual behavior, which may be painful, intrusive, or overwhelming because of its novelty and sexual nature. This power may also be manifest in manipulation of the child into compliance. The child has little knowledge about the societal and personal implications of being involved in sex with an adult; in contrast, the adult has sophisticated knowledge of the significance of the encounter. The child's lack of power and knowledge means the child cannot give informed consent.[36] Finally, although in some cases the adult may perceive him/herself providing pleasure to the child, the main object is the gratification of the adult. That is what is wrong about sex between adults and children.

The Impact of Sexual Abuse

Regardless of the underlying causes of the impact of sexual abuse, the problems are very real for victims and their families. A number of attempts have been made to conceptualize the effects of sexual abuse.[37 38 39 40] In addition, recent efforts to understand the impact of sexual abuse have gone beyond clinical impressions and case studies. They are based upon research findings, specifically controlled research in which sexually abused children are compared to a normal or nonsexually abused clinical population. There are close to 40 such studies to date.[41]

Finkelhor,[42] whose conceptualization of the traumatogenic effects of sexual abuse is the most widely employed, divides sequelae into four general categories, each having varied psychological and behavioral effects.

- **Traumatic sexualization**. Included in the psychological outcomes of traumatic sexualization are aversive feelings about sex, overvaluing sex, and sexual identity problems. Behavioral manifestations of traumatic sexualization constitute a range of hypersexual behaviors as well as avoidance of or negative sexual encounters.

- **Stigmatization**. Common psychological manifestations of stigmatization are what Sgroi calls "damaged goods syndrome"[43] and feelings of guilt and responsibility for the abuse or the consequences of disclosure. These feelings are likely to be reflected in self-destructive behaviors such as substance abuse, risk-taking acts, self-mutilation, suicidal gestures and acts, and provocative behavior designed to elicit punishment.

- **Betrayal**. Perhaps the most fundamental damage from sexual abuse is its undermining of trust in those people who are supposed to be protectors and nurturers. Other psychological impacts of betrayal include anger and borderline functioning. Behavior that reflects this trauma includes avoidance of investment in others, manipulating others, re-enacting the trauma through subsequent involvement in exploitive and damaging relationships, and engaging in angry and acting-out behaviors.

- **Powerlessness**. The psychological impact of the trauma of powerlessness includes both a perception of vulnerability and victimization and a desire to control or prevail, often by identification with the aggressor. As with the trauma of betrayal, behavioral manifestations may involve aggression and exploitation of others. On the other hand, the vulnerability effect of powerlessness may be avoidant responses, such as dissociation and running away; behavioral manifestations of anxiety, including phobias, sleep problems, elimination problems, and eating problems; and revictimization.

Our understanding of the impact of sexual abuse is frustrated by the wide variety of possible effects and the way research is conducted. Researchers do not necessarily choose to study the same effects, nor do they use the same methodology and instruments. Consequently, a particular symptom, such as substance abuse, may not be studied or may be examined using different techniques. Furthermore, although most studies find significant differences between sexually abused and nonabused children, the percentages of sexually abused children with a given symptom vary from study to study, and there is no symptom universally found in every victim. In addition, often lower proportions of sexually abused children exhibit a particular symptom than do nonabused clinical comparison groups. Finally, although some victims suffer pervasive and debilitating effects, others are found to be asymptomatic.[44]

In addition, a variety of factors influence how sexual maltreatment impacts on an individual. These factors include the age of the victim (both at the time of the abuse and the time of assessment), the sex of the victim, the sex of the offender, the extent of the sexual abuse, the relationship between offender and victim, the reaction of others to knowledge of the sexual abuse, other life experiences, and the length of time between the abuse and information gathering. For example, the findings for child victims and adult survivors are somewhat different.

It is important for professionals to appreciate both the incomplete state of knowledge about the consequences of sexual abuse and the variability in effects. Such information can be helpful in recognizing the wide variance in symptoms of sexual abuse and can prevent excessive optimism or pessimism in predicting its impact.

INDICATORS OF CHILD SEXUAL ABUSE

Sexual abuse may result in physical or behavioral manifestations. It is important that professionals and the public know what these are because they signal possible sexual abuse. However, very few manifestations (e.g., gonorrhea of the throat in a young child) are conclusive of sexual abuse. Most manifestations require careful investigation or assessment.

Unfortunately, early efforts at cataloging indicators of sexual abuse were problematic. They included extremely rare findings, such as blood in a child's underpants and signs that could be indicative of many problems or no problem at all, such as "comes early to school and leaves late." Recent efforts to designate signs of sexual abuse are more helpful.

- **They differentiate between physical indicators and psychosocial indicators**. Although physical indicators may be noted by many people, a definitive determination is generally made by a medical professional. Similarly, anyone may observe psychosocial indicators; however, often but not always, a mental health professional is responsible for forming an opinion that the symptoms are indicative of sexual abuse.

- **A differentiation is made between higher and lower probability indicators**. That is, some indicators are diagnostic of sexual abuse, whereas others may be consistent with or suggestive of sexual abuse but could indicate other circumstances or conditions as well.

In this chapter, higher probability findings and lower probability physical indicators are discussed first. A comparable discussion of psychosocial indicators will follow. It should not be surprising that the indicators specified in this chapter are similar to the effects described in the previous chapter since indicators are to a large extent the effects of sexual abuse before disclosure. Therefore, these indicators should become a focus of treatment and not simply used to support or rule out an allegation of sexual abuse.

MEDICAL INDICATORS OF CHILD SEXUAL ABUSE

Significant progress has been made in the medical field in the determination of sexual abuse. Medical professionals are no longer limited to the presence or absence of a hymen as the indicator of possible sexual abuse. A variety of types of genital findings have been documented. In addition, notable progress has been made in identifying anal findings. Moreover, physicians are able to describe the effects of different kinds of sexual activity, and subtle findings can be documented using magnification (a colposcope or otoscope).

However, this progress is not without its controversies. Knowledgeable and conscientious physicians may differ regarding conclusions about certain physical findings. This difference of opinion is primarily due to the fact that data collection regarding the physical signs of sexual abuse has preceded careful documentation of characteristics of genitalia and anal anatomy of children who have not been sexually abused and of variations among normal children. These legitimate differences of opinion have been augmented by challenges to the medical documentation from defense attorneys, their expert witnesses, and alleged offenders.

It is also important to appreciate that for the majority of sexually abused children there are no physical findings. These findings, particularly vaginal ones, are most useful with prepubertal victims. As children become older, the possibility of consensual sexual activity needs to be considered. Further, changes that occur with puberty render insignificant some symptoms that have great significance in young children.

Two High-Probability Physical Indicators

Despite the progress noted above, the highest probability indicators are ones identified over 10 years ago. They are:

- pregnancy in a child and
- venereal disease in a child.

The reason these findings are high probability is because there is little dispute over the fact that they require sexual activity.

Some professionals assume that pregnancy in a child less than age 12 signals abuse although others designate the age of 13 or 14. Of course, not all situations in which children of these ages become pregnant are abusive, and pregnancy in older adolescents can be a consequence of sexual abuse.

Venereal disease may be located in the mucosa of the vagina, penis, anus, or mouth. The upper age limits for venereal disease raising concern about sexual abuse are similar to those for pregnancy. In addition, there is a lower age limit, usually of 1 or 2 months, because infants may be born with venereal disease acquired congenitally if the mother has the disease.

Interestingly, variations are found within the medical community regarding the certainty that sexual activity causes particular venereal diseases in children. Specifically, there is consensus that syphilis and gonorrhea cannot be contracted from toilet seats or bed sheets, but some differences of opinion exist about other venereal diseases (genital herpes, condyloma acuminata or venereal warts, trichomonas vaginalitis, and urogenital chlamydia), despite the conclusion that such infections are caused by sexual contact in adults.[45] In a recent review of the research, Smith, Benton, Moore, and Runyan conclude that there is "strong evidence" that all of these venereal diseases are sexually transmitted, except for herpes, for which there is "probable evidence." They also review the evidence on human immunodeficiency virus (HIV) and conclude that there is strong evidence it is sexually transmitted as well, unless contracted pre- or perinatally.[46]

Genital Findings

High-probability findings specific to the genitalia include the following:

- semen in the vagina of a child,
- torn or missing hymen,
- other vaginal injury or scarring,
- vaginal opening greater than 5 mm, and
- injury to the penis or scrotum.

Semen in the vagina is the highest probability finding, but it is uncommon.

Although there is a fair amount of variability among girl children in the extent, shape, and other characteristics of hymens,[47] the complete absence of or a tear in the hymen of a young girl is indicative of sexual abuse. In older girls, it is important to determine whether other sexual activities may account for the absence or the tear. Conditions such as bumps, friability, and clefts in the hymen may be a result of sexual abuse, but they are also found in girls without a reported history of sexual abuse.[48]

Health care professionals document and describe injuries to or bleeding from the vaginal opening by likening it to a clock face, 12 o'clock being the anterior midline and 6 o'clock the posterior. Abrasions, tears, and bruises to the vagina between 3 and 9 o'clock, or to the posterior, are more likely to be the result of penile penetration, whereas injuries between 9 and 3 o'clock, or anteriorly, are more likely the consequence of digital manipulation or penetration.[49]

There is some controversy regarding what transverse diameter to use as a guideline for differentiating between girls with genital evidence consistent with penetration and those with no genital evidence, with measures ranging from 4 to 6 mm being advocated as indicative of sexual abuse.[50] One factor that may affect findings is the age of the child, with the expectation that older girls will have larger vaginal openings. Heger, an expert in physical findings related to sexual abuse, discounts the importance of hymenal transverse diameter, noting that it varies in size depending on the position in which the child is examined.[51] It is also important to note that not all girls who have a reported history of penetration evidence enlarged vaginal openings, tears, abrasions, or bruising.

Absent another explanation for an injury to the penis, which is consistent with the child's account of the abusive incident, the injury should be considered indicative of sexual abuse. Bite marks, abrasions, redness, "hickeys," scratches, or bruises may be found.

Lower probability genital findings are as follows:

- vaginal erythema,
- increased vascularity,
- synechiae,
- labial adhesions,
- vulvovaginitis, and
- chronic urinary tract infections.

Erythema or redness and swelling might be caused by genital manipulation or intrusion perpetrated by a significantly older person. However, it might also be the result of poor hygiene, diaper rash, or perhaps the child's masturbation.[52] Increased vascularity, synechiae, and labial adhesions may be a consequence of sexual abuse, but they are common findings in children with other genital complaints.[53]

Vulvovaginitis and chronic urinary tract infections can be sequelae of sexual abuse but also can be caused by other circumstances, such as poor hygiene, a bubble bath, or, in the case of urinary tract infections, taking antibiotics.

Anal Findings

The following are high-probability findings:

- destruction of the anal sphincter,
- perianal bruising or abrasion,
- shortening or eversion of the anal canal,
- fissures to the anal opening,
- wasting of gluteal fat, and
- funneling.

Very occasionally there will be a finding of total absence of anal sphincter control, indicative of chronic anal penetration. If there has been forceful anal penetration, it may result in bruising and scrapes. A shortening or eversion of the anal canal has been found in very young children who have been chronically anally penetrated.[54] Perianal fissures and scars from fissures are thought to be indicative of sexual abuse except when they occur at 12 o'clock and 6 o'clock,[55] in which case they may be the result of a large stool. If the fissure is wider externally and narrows internally, this is consistent with object penetration of the anus. The converse finding is consistent with the passage of a large, firm stool.[56] Funneling and wasting of the gluteal fat around the anal opening can occur from chronic anal penetration. This is a rare finding in children but may be found in male adolescent prostitutes. The following anal findings are lower probability:

- perianal erythema,
- increased perianal pigmentation,
- perianal venous engorgement, and
- reflex anal dilatation.

Perianal erythema, increased pigmentation, and venous engorgement are all physical findings noted in children who have a history of anal penetration. However, these conditions also have been reported in substantial numbers of children with no reported history of sexual abuse, suggesting that they can be caused by other conditions.[57] In the case of the first two findings, these conditions could be a consequence of poor hygiene.

A finding that is in some dispute is reflex anal dilatation, that is, gaping of the anus or the twitching of the anal sphincter at the time of physical exam. Some physicians believe that it is a consequence of anal penetration,[58] but others have noted this finding in children whose lower bowel is full of stool. However, gaping of 20 mm or more is thought to be indicative of anal penetration.[59]

Oral Findings

Generally oral sex leaves little physical evidence. The only physical findings that have been noted are the following:

- injury to the palate or

- pharyngeal gonorrhea.

Sometimes the child will sustain an injury to the soft or hard palate from being subjected to fellatio. This may cause bruising, especially pinpoint bruises called petechiae, or abrasions.[60] Children may also contract pharyngeal gonorrhea as a consequence of oral sex, as described above.

PSYCHOSOCIAL INDICATORS OF CHILD SEXUAL ABUSE

Comparable efforts to identify the psychosocial indicators of child sexual abuse have been made by mental health professionals. In 1985, 100 national experts in sexual abuse met to develop criteria for the "Sexually Abused Child Disorder," in the hope that it would be included in the *Diagnostic and Statistical Manual Three-Revised* (DSMIII-R). It was not, but the effort remains important. The criteria of the "Sexually Abused Child Disorder" differentiate three levels of certainty (high, medium, and low) and vary by developmental stage. These criteria include both sexual and nonsexual indicators.[61]

The work of Friedrich focuses on sexualized behavior, indicators unlikely to be found in other traumatized or normal populations. His Child Sexual Behavior Inventory has been field-tested on 260 children between 2 to 12 years of age, who were alleged to have been sexually abused and 880 children not alleged to have been sexually abused. It was found to reliably differentiate the two types of children. However, a substantial proportion of children in Friedrich's research, determined sexually abused, are not reported to engage in sexualized behavior. Moreover, children who learn about sex from nonabusive experiences may engage in sexualized behavior.

In this manual, a two-category typology of behavioral indicators is proposed:

- sexual indicators, generally being higher probability indicators; and

- nonsexual behavioral indicators, usually considered lower probability.

Sexual Indicators

Sexual indicators vary somewhat depending on the child's age. The discussion of these indicators will be divided into those likely to be found in younger sexually abused children (aged 10 or younger) and those likely to be found in older sexually abused children (older than age 10). However, this distinction is somewhat arbitrary, and within these two groups there are children at very different developmental stages. Finally, indicators that are important for children of all ages are noted.

Sexual Indicators Found in Younger Children

These behaviors are high-probability indicators because they represent sexual knowledge not ordinarily possessed by young children.

- Statements indicating precocious sexual knowledge, often made inadvertently.

  - A child observes a couple kissing on television and says that "the man is going to put his finger in her wee wee."

- A child comments, "You know snot comes out of Uncle Joe's ding dong."

- Sexually explicit drawings (not open to interpretation).

  - A child draws a picture of fellatio.

- Sexual interaction with other people.

  - Sexual aggression toward younger or more naive children (represents an identification with the abuser).

  - Sexual activity with peers (indicates the child probably experienced a degree of pleasure from the abusive activity).

  - Sexual invitations or gestures to older persons (suggests the child expects and accepts sexual activity as a way of relating to adults).

- Sexual interactions involving animals or toys.

  - A child may be observed sucking a dog's penis.

  - A child makes "Barbie™* dolls" engage in oral sex.

The reason sexual knowledge is more compelling when demonstrated by younger children than older ones is that the latter may acquire sexual knowledge from other sources, for example, from classes on sex education or from discussions with peers or older children. Even younger children may obtain knowledge from sources other than abuse. However, children are not likely to learn the intimate details of sexual activity nor for example, what semen tastes like and penetration feels like without direct experience.

Another indicator often cited is excessive masturbation. A limitation of this as an index of sexual abuse is that most children (and adults) masturbate at some time. Thus, it is developmentally normal behavior, which is only considered indicative of sexual abuse when "excessive." However, a determination that the masturbation is excessive may be highly subjective. The following guidelines may be helpful.

- Masturbation is indicative of possible sexual abuse if:

  - Child masturbates to the point of injury.

  - Child masturbates numerous times a day.

  - Child cannot stop masturbating.

  - Child inserts objects into vagina or anus.

  - Child makes groaning or moaning sounds while masturbating.

  - Child engages in thrusting motions while masturbating.

---

* Barbie™ is a registered trademark of Mattel, Inc.

Sexual Indicators Found in Older Children

As children mature, they become aware of societal responses to their sexual activity, and therefore overt sexual interactions of the type cited above are less common. Moreover, some level of sexual activity is considered normal for adolescents. However, there are three sexual indicators that *may* signal sexual abuse.

- sexual promiscuity among girls,
- being sexually victimized by peers or nonfamily members among girls, and
- adolescent prostitution.

Of these three indicators, the last is most compelling. One study found that 90 percent of female adolescent prostitutes were sexually abused.[62] Although there has not been comparable research on male adolescent prostitutes, there are clinical observations that they become involved in prostitution because of sexual abuse.[63]

A High-Probability Sexual Indicator for All Children

Finally, when children report to anyone they are being or have been sexually abused, there is a high probability they are telling the truth. Only in rare circumstances do children have any interest in making false accusations. False allegations by children represent between 1 and 5 percent of reports.[64] Therefore, unless there is substantial evidence that the statement is false, it should be interpreted as a good indication that the child has, in fact, been sexually abused.

Nonsexual Behavioral Indicators of Possible Sexual Abuse

The reason that nonsexual behavioral symptoms are lower probability indicators of sexual abuse is because they can also be indicators of other types of trauma. For example, these symptoms can be a consequence of physical maltreatment, marital discord, emotional maltreatment, or familial substance abuse. Nonsexual behavioral indicators can arise because of the birth of a sibling, the death of a loved one, or parental loss of employment. Moreover, natural disasters such as floods or earthquakes can result in such symptomatic behavior.

As with sexual behaviors, it is useful to divide symptoms into those more characteristic of younger children and those found primarily in older children. However, there are also some symptoms found in both age groups.

Nonsexual Behavioral Indicators in Young Children

The following symptoms may be found in younger children:

- sleep disturbances;
- enuresis;
- encopresis;
- other regressive behavior (e.g., needing to take transitional object to school);

- self-destructive or risk-taking behavior;
- impulsivity, distractibility, difficulty concentrating (without a history of nonabusive etiology);
- refusal to be left alone;
- fear of the alleged offender;
- fear of people of a specific type or gender;
- firesetting (more characteristic of boy victims);
- cruelty to animals (more characteristic of boy victims); and
- role reversal in the family or pseudomaturity.

Nonsexual Behavioral Indicators in Older Children

- eating disturbances (bulimia and anorexia);
- running away;
- substance abuse;
- self-destructive behavior, e.g.,
  - suicidal gestures, attempts, and successes and
  - self-mutilation;
- incorrigibility;
- criminal activity; and
- depression and social withdrawal.

Nonsexual Behavioral Indicators in All Children

Three types of problems may be found in children of all ages:

- problems relating to peers,
- school difficulties, and
- sudden noticeable changes in behavior.

Summary

Sexually abused children may manifest a range of symptoms, which reflect the specifics of their abuse and how they are coping with it.

Suspicion is heightened when the child presents with several indicators, particularly when there is a combination of sexual and nonsexual indicators. For example, a common configuration in female adolescent victims is promiscuity, substance abuse, and suicidal behavior. Similarly, the presence of both behavioral and physical symptoms increases concern. However, the absence of a history of such indicators does not signal the absence of sexual abuse.

INVESTIGATION OF CHILD SEXUAL ABUSE

This chapter describes the role of Child Protective Services (CPS) in the investigation of cases of sexual abuse, the structure of the investigation, and risk assessment in child sexual abuse. Specific techniques for interviewing children and making a determination about the validity of an allegation are presented in the next chapter.

THE ROLE OF CPS

CPS is the local authority, housed in public social services agencies, responsible for investigation of and intervention in cases of suspected sexual abuse. Its mandate to protect children can be found in Federal and State legislation. Typically, CPS is only responsible for intervening in those situations in which the offender is in a caretaking role for the child. Law enforcement agencies are usually responsible for the investigation of cases involving offenders in noncaretaking roles. However, CPS may also become involved in situations in which the offender is a nonfamily member but the child's caretaker fails to protect the child from the offender.

Health care, mental health, and education professionals are mandated in most States to make a timely report of suspected maltreatment to CPS. Other persons may report.*

Upon receiving a report, CPS conducts an investigation, within a specified time frame (typically within 24 or 48 hours or up to 5 days, depending on the State). The goal of CPS is to determine whether or not maltreatment has occurred and is likely to occur in the future and whether the child's safety can be ensured in the home. In forming conclusions about maltreatment and risk, the worker receives input from other professionals and from non-professionals (e.g., parents, children, neighbors, relatives), but the final decisions lie with CPS.

If the child is considered in danger, CPS takes steps to ensure the child's safety. CPS's first goal is to ensure the child's protection within his/her own home. When the child's safety cannot be ensured in the home, intervention may involve removal of the child and placement with a relative or a foster family, or it may entail getting the offender out of the home. The latter strategy is preferred in cases of sexual abuse. Actions resulting in removal *usually* require the intervention of the juvenile or family court. The reader is referred to another manual in this series, *Working With the Courts in Child Protection*.

Sexual abuse cases are handled somewhat differently from other referrals to CPS. Many State statutes mandate collaboration between CPS and law enforcement when the report is of sexual abuse. This often results in joint investigation and always in sharing of information. The mandate of the law enforcement agency is not to help families with their problems but to gather evidence toward the prosecution of offenders. As a consequence, the CPS goal of keeping families intact or family reunification may be compromised in

---

* The range of professional required to report to CPS varies somewhat from State to State, and in some States all persons are mandated to report. Professionals should consult their State child protection reporting law to determine if they are mandated reporters.

sexual abuse cases. This is not necessarily a negative outcome. As discussed in the final chapter, offenders vary in their treatability.

Another way in which sexual abuse cases are likely to challenge the child protection system is with regard to the system's expectation that intervention will be short term. CPS is structured to conduct crisis intervention. In general, however, intrafamilial sexual abuse is not a short-term problem, but rather one that requires extended intervention.

THE STRUCTURE OF THE INVESTIGATION

Communities vary considerably in how they structure investigations of sexual abuse. However, generally there are four types of professionals involved—CPS caseworkers, law enforcement officers, physicians, and mental health professionals. Other professionals may be involved as well.

Communities also vary in the extent to which their investigation is well organized and coordinated. Some communities are fortunate enough to have multidisciplinary team composed of members actively involved in the investigation or professionals who serve as consultants to frontline staff. In other communities, the roles of CPS, law enforcement, and health care providers are well integrated, but the involvement of other professionals and the interface with the court are not well articulated. In still others, unfortunately, the investigation is haphazard and poorly organized so that professionals are not aware of what others are doing or are working at cross purposes. Although there is considerable variability by community as to who does what and, to a lesser extent, when it is done, there nevertheless are specific components to a good investigation.

Discussions of data gathering from the referral source, the child interview, the medical examination, the interview with the nonoffending parent, and the interview with the alleged offender follow. These discussions assume a case of intrafamilial sexual abuse in which there is only one offender, with the mother the nonoffending parent and the father figure the offender. Obviously, adjustments need to be made for other configurations.

Gathering Information From the Referral Source

The investigative process usually begins with gathering information from the reporting party. The interview with the reporter should include an exploration of what the child has said or done that the reporter thinks indicates possible sexual abuse, his/her reactions to this information, and the reporter's knowledge of any other parties with relevant information.

The Child Interview

There are several issues related to the child interview that should be determined before it takes place. These include where it should occur, who should be present, how information from the interview will be recorded, and how many interviews are needed.

The interview should occur in a location the child perceives as a "safe place." In most instances, this will not be the child's home, but it may be the child's school, a therapist's office, a child interview room at the CPS office or police station, or a Children's Advocacy Center. Originating in Huntsville, Alabama, this center is a child-oriented facility developed specifically for interviewing and providing services to sexually abused children. It represents a successful strategy for addressing the often fragmented and potentially alienating approach to service delivery that characterizes how many communities handle child sexual abuse. This model has been replicated in other communities. When used for interviewing children, usually specialized facilities are equipped with one-way mirrors, so that the interview can be observed or videotaped.

As mentioned above, investigations may be conducted conjointly by CPS and law enforcement. In some communities, CPS is responsible for the child interview, and law enforcement interviews the alleged offender. In other communities, both are present at the child interview, although only one usually conducts the interview. Alternatively, one of the investigators (and relevant others, such as a mental health expert or an assistant prosecutor) may be behind the one-way mirror. Having more than one person present during the child interview may eliminate the need for multiple interviews.

Some record should be made of information gathered during the child interview. This may be a videotape, an audiotape, or notes. Notes are more easily taken by someone who is not interviewing the child. Each of these methods of data gathering has its strengths and weaknesses.[65]

The number of interview sessions usually depends on who is conducting the investigation. In the majority of cases, CPS conducts one interview. If no confirming evidence emerges and there is no other supporting evidence, the CPS worker will usually deny the case after a single interview. Similarly, hospital-based programs that conduct investigations for law enforcement and CPS conduct a medical exam and a single interview, unless the interview is inconclusive or there are confirming medical findings and no disclosure. In contrast, mental health experts assessing children at the request of mandated agencies or the courts often conduct several interviews. In the latter instances, the child is usually in a protective environment.

It is usually optimal to interview the child before interviewing the parents. The rationale for this order is that, in most cases, the child's statements and behavior are the primary means for determining whether sexual abuse occurred. Consequently, having some indication of the likelihood of sexual abuse and, if likely, knowing its specifics may be useful in later interviews with the nonoffending parent and alleged offender.

As part of the investigation, it is important that all children, both males and females in the target victim's family or abusive circumstance (e.g., day care center) are interviewed. There are two reasons for this. First, offenders generally have multiple victims, not a single one.[66] Second, even if other children are not victims, they may be witnesses.

A question of strategy is whether, in situations in which there are potentially multiple victims, children should be interviewed separately or as a group. Disclosures may be inhibited or facilitated by either practice. For example, a child may be helped to describe sexual abuse by the presence of an older, more forthcoming sibling. Alternatively, the presence of siblings may reinforce the family prohibition against telling secrets. An additional consideration is that a more sophisticated understanding of the abuse and its significance may be obtained by observing the interaction among children. Because of real or apparent issues regarding contagion, children should initially be interviewed separately, with conjoint interviews occurring later.

The Medical Examination

Views regarding the advisability of a medical examination have changed considerably in recent years, largely because of a perspective offered by Sgroi.[67] Professionals had many reservations about the appropriateness of a medical exam for sexually abused children because of its potential to retraumatize the child and because the probability of supportive medical findings was generally remote. However, Sgroi advocated the use of a medical exam as a context to assure the child and her/his caretakers that she/he was undamaged and intact. Thus, negative findings become positive.

Today, most professionals working in sexual abuse adhere to Sgroi's viewpoint. Thus, the child should receive a medical examination at some point during the investigation. Generally, physicians only see the necessity of an immediate exam when the abuse is quite recent and/or there is concern about injury or disease. Otherwise the exam can be postponed for a few hours until there is an experienced health care professional

available with sufficient time available to conduct the genital exam and necessary tests in the context of a general physical exam.[68]

The Interview With the Nonoffending Parent

The investigative or assessment interview with the mother has several purposes:

- to gather additional information about the likelihood of the sexual abuse;
- to determine whether the mother is protective and supportive of the victim;
- in some instances, to ascertain if the mother has had a role in prompting the child to make or recant an allegation; and
- to understand the causes or dynamics leading to the sexual abuse.

Mothers may provide information that either supports or refutes the child's allegation. However, as noted earlier, the child interview is the primary context for gathering information to determine the likelihood of the sexual abuse. The typical initial reaction of mothers confronted with an allegation of sexual abuse is denial, both psychological and actual.

It is important for the investigator to evaluate carefully a mother's protests that "this couldn't have happened because the child is never alone with the alleged offender," that "the child has a long history of telling lies," or that "the child is making this allegation because she is jealous of the new baby" in light of the mother's propensity to disbelieve or deny. Nevertheless, there can be circumstances in which mothers provide information that rules out sexual abuse.

Many mothers do believe their child's allegation and provide corroborating information. There are also situations in which doubting mothers corroborate the child's statements, even if inadvertently.

A major purpose of the initial interview with the mother is to assess her ability to provide support for the child. Mothers whose children have been sexually victimized by someone who is close to them, such as a spouse, are placed in a very difficult position. Often they have no inkling of the abuse until confronted by a professional. Mothers who are consciously aware of the victimization and condone or accept it are extremely rare. However, some mothers ignore signs of sexual abuse, for a variety of reasons, or are preoccupied with matters other than their children's well-being.

As already noted, initial denial is common. However, a mother can decide her child's well-being takes priority and provide protection, even as she struggles to integrate the allegations with her perceptions of the alleged offender and the child. Mothers should not be disparaged because they require time and sometimes treatment to believe their children have been sexually abused. Only when denial persists for months in the face of compelling evidence, and the victim is blamed, should the mother be considered unworkable.

The following factors should be examined to determine whether the mother will act in the child's best interest:

- the quality of her relationship with the child, which may be mostly positive, ambivalent, or mostly negative;
- her level of dependency, particularly on the offender; and

- her willingness and/or ability to protect the victim, whether or not she has lingering concerns about the veracity of the allegations.

In addition, it is important to appreciate that mothers may not be steadfast. They often vacillate regarding their belief about the abuse and their support of the victim. For example, a mother may initially align herself with the child and later change her position when confronted by the alleged offender or with the practical and psychological consequences of a provictim stance. Alternatively, she may appear supportive of the child with the professionals but behave otherwise away from their presence.

A very different issue may need to be pursued in the mother's interview in some circumstances in which there is an antagonistic relationship between the mother and the alleged offender. Such may be the case when the mother is in the process of divorcing the offender, or they are already divorced, and there are disputes regarding custody or visitation. That issue is whether the mother is making, is supporting, or has induced a fabricated allegation of sexual abuse. The research indicates that between 50 and 75 percent of allegations that arise in the context of divorce are "likely" or "substantiated" and that consciously made false allegations are quite rare.[69 70 71]

Finally, the interview with the mother can be used to gather information about the causes or dynamics of the sexual abuse. CPS caseworkers will explore this in less depth than mental health professionals. Information to be obtained from the mother and the rationale for seeking it can be found in Chart 1.

The Interview With the Alleged Offender

Jurisdictions vary as to whether law enforcement or CPS conduct the initial interview with the alleged offender. It may be preferable for law enforcement to take the lead role in order to obtain a legally admissible confession. In addition, the law enforcement officer can obtain a warrant to search the premises and seize relevant physical evidence and has the capacity to "preserve the chain of evidence," so that the physical evidence will be admissible in court. Police officers are also the only professionals who can make arrests.

There are parallels in the expectations the investigator has for interviews with the alleged offender (father/father figure) and with the mother. The interviewer seeks additional information regarding the allegations, tries to assess the quality of the offender's relationships with the victim and other family members, and attempts to understand the causes of the abuse.

There is a possibility that the alleged offender will provide information that either refutes or supports the allegation. However, the interviewer must appreciate that the alleged offender has a substantial vested interest in convincing professionals and others, including his wife, that the child is either lying, fantasizing, mistaken, or emotionally disturbed, when in fact the child's allegations are true. Consequences for him are dire, including loss of his child, his family, and perhaps his job, and the prospect of prison.

Information the alleged offender provides regarding the abuse must be viewed with this understanding. Nevertheless, there are cases in which the accused provides a reasonable alternative explanation for the child's statements. This may be the case when the child's statements are rather vague or relate to possible child care behaviors.

Some offenders will confess when confronted with the allegations. The probability of confession is substantially increased when the offender knows that treatment is available, even when accompanied by some punishment (i.e., jail time).[72]

Chart 1. Interview Data Gathered from the Mother

	INFORMATION	RATIONALE
1.	Past history of physical abuse, neglect, etc.	Potential for problems in parenting
2.	Past history of sexual abuse	Possible propensity to choose a sexual abuser as a partner, difficulties in perceiving risk to her children, propensity to overreact and perceive risk when not present
3.	Current living situation	Other potential victims, availability of social supports, degree of independence of alleged offender, prosence or use of weapons in home
4.	Education and employment history	Ability to be independenbt of the alleged offender, to support self and children
5.	Parenting	Ability to provide for the needs of the child, including nurturance and protenction; perception of the victim; evidence of "role reversal"
6.	Discipline	Possible punitive, abusive, or neglectful treatment; possible scapegoating of the victim
7.	Partner relationship	Possible patterns regarding choices of exploitive, abusive and dominant or dependant partners; ability to see child's needs as more important that partners's or her need for a partner
8.	Sexual history	Possible pattern of being sexually exploited, promiscuous, or dysfunctional; reports of sexual behavior by the alleged abuser that might assist in understanding dynamics of sexual abuse
9.	Substance abuse	Obstacle to parenting, index of overall functioning, possible index of ability to function independent of the alleged offender
10.	Mental illness	Index of overall function, index of ability to protect the child; possible problems in reality testing related to abuse allegation and other matters
11.	Criminal history	Index of overall functioning

It is always important to assess the quality of the alleged offender's relationship with the victim and others in the family. Such information is helpful in determining risk and whether it is advisable to work later toward some relationship or reconciliation between victim and offender, if abuse is established.

One of the significant dilemmas of diagnosis of sex offending is that there is no psychological test(s) or series of responses to interview questions that can rule out sexual abuse.[73] Similarly, the only response from the alleged offender assessment that is an absolute is the confession. In most instances, the interviewer elicits information from the alleged offender that *could* imply a history of sexual offending but might also be explained in other ways.

As a further complication, there are many different types of sex offenders. For example, some offenders present with pervasive dysfunction, and others function reasonably well, except for their sexual deviance. The sexual orientation of some offenders is primarily toward children, whereas others may be primarily aroused by peers and under certain circumstances show a sexual response toward children.

Chart 2 suggests general information to be sought from the alleged offender and the rationale for seeking it. The general areas for assessment are the same for mothers and offenders; however, the rationale for exploring them may be different or have a different emphasis. For example, the ability to exercise impulse control and the willingness to be held accountable for own behaviors are major areas of assessment with alleged offenders, requiring more thorough exploration.

It is important to appreciate that offenders and sometimes mothers have a vested interest in concealing certain information and/or presenting themselves in a favorable light. Therefore, it is essential to gather additional information from other sources, including other family members, the family's informal social network, and professionals, particularly past or current therapists.

RISK ASSESSMENT

If it is determined by CPS or law enforcement that a child has been sexually abused, the case is one of intrafamilial abuse, and the child is at home, then it is necessary to make a determination of risk to the child if she/he stays in that environment. Following are three types of potential risk:

- Risk of additional sexual abuse
- Risk of physical abuse
- Risk of emotional maltreatment

Types of Emotional Risk

In most instances, the child is at greater risk for emotional maltreatment than additional sexual abuse immediately after disclosure. There are a variety of types of emotional abuse the victim may suffer.

- **The child may be disbelieved by her/his mother, siblings, and/or extended family**.
- **The child may be blamed for the sexual abuse**. She/he may be told she/he was seductive. The child may believe she/he allowed it because she/he got special favors from the offender.
- **The child may be rejected by her/his family**. Mother is angry at her/him. The child's siblings are angry because she/he has caused them embarrassment and loss of their father.

Chart 2. Interview Data Gathered from the Offender

	INFORMATION	RATIONALE
1.	Past history of physical abuse, neglect, etc.	Potential for deficits in nurturing skills, potential lack of empathy with victim
2.	Past history of sexual abuse	Propensity to become a sexual abuser
3.	Current living situation	Safety of the alleged victim, other potential victims
4.	Education and employment history	Index of overall function, including impulse control problems (frequent job changes) and access to potential victims
5.	Parenting	Ability to provide adequate care (sexual abuse aside), appropriate vs. inappropriate investment in the children, distortions in views of children
6.	Discipline	Possible physically or emotionally abusive behavior, impulsive reactions, unrealistic expectations of children,blaming alleged victim for allegations.
7.	Partner relationship	Possible abusive relationships and/or serious problems in past or current object relations, potential factors that might increase risk for sexual abuse
8.	Sexual history	Possible evidence of other paraphilias, availability and use of sexual outlets, level of sexual experience, knowledge and beliefs about sex
9.	Substance abuse	Substance as a disinhibitor to sexual activity with children, possible use of substance to cope with guilt regarding sexual abuse, link between substance abuse and criminal activity, index of superego and overall functioning
10.	Mental illness	Potential for delusional system justifying sexual activity with children, index of overall functioning
11.	Mental retardation	Potential source of problems in judgment or impulse control, index of overall functioning, blockage of gratification in other aspects of life
12.	Criminal history	Index of impuse control and overall functioning, sex crimes signal increased risk for sexual abuse, index of superego functioning
13.	Sexual abuse	Possible confession or other incriminating statements, propensity to blame victim, level of responsiblity taken for the abuse

- **The child may be blamed for the consequences of disclosure**. Because she/he told, the father is going to have to leave the home, going to lose his job, going to jail. Now the mother will have to divorce the father. Now the family has to go on public assistance.

- **The child may be pressured to recant**.

Factors To Consider in Risk Assessment

If professionals determine that the child is at risk for future sexual, physical, or emotional maltreatment, then some plan should be made to protect her/him. Making a determination of risk is no easy task. Families may be quite secretive. Furthermore, decisions may need to be made on an emergency basis without complete information. Nevertheless, the following factors need to be considered:

- **Type(s) of sexual abuse**. The more intrusive the sexual acts and the greater the number of types of sexual activity, generally the riskier the situation. However, risk in situations involving "just" fondling should not be minimized.

- **Characteristics of the abuse situation**. Relevant characteristics are frequency of sexual activity, its duration, the presence or absence of force, and the use of threats. The more frequent and the longer the abuse has gone on, the harder it will be for the offender to refrain. The use of force and threats also signal increased risk. If the threats are manipulative, such as "You'll break up the family if you tell," the risk is for emotional maltreatment. If the threats are of bodily harm, then the risk is for physical abuse.

- **Victim age**. Generally, younger victims are more vulnerable than older ones.

- **Relationship between victim and offender**. As a rule, the greater the degree of relatedness, the greater the risk, especially for emotional abuse. Further, an offender who lives with the family poses a greater threat for sexual and emotional abuse than one outside the family.

- **Number of victims**. The more children the offender has sexually abused, the greater difficulty he will have controlling his sexual behavior.

- **Number of offenders**. Multiple offenders, especially if they are all within the family, mean the family provides a very risky environment.

- **Reactions and functioning of the nonoffending parent**. As noted earlier, factors include the mother's reaction to knowledge of the sexual abuse, her relationship with the victim, and her level of dependency on the offender. If she disbelieves the child, is unwilling to attend to the child's best interest, has a poor relationship with the child, or is dependent on the offender, then the child is at risk for emotional abuse and perhaps additional sexual abuse in the home.

- **Reaction of the offender**. As noted earlier, a confession, while unlikely, would mean less risk for the victim. Greater risk exists if the alleged offender denies the sexual abuse, especially if he blames the victim for disclosure. In either case, the offender's continued presence in the home poses a greater risk of abuse and emotional maltreatment.

- **The presence of other problems in family functioning**. These problems might include substance abuse, family violence, both spouse abuse and child abuse, mental illness, and mental retardation. Their effect depends on how many of these problems exist in the family, who has the problem, and the severity of the problem. However, their presence generally increases risk to the victim.

The choices are generally two—remove the offender or remove the victim. There is professional agreement that removal of the offender is preferable. Even though this strategy may not be as certain in preventing additional sexual, physical, and emotional abuse, it has the considerable advantage of providing a clear message to the victim, the offender, and the family that he is the person who has done something wrong and that this is serious.

If he is denying the abuse, the offender's removal minimizes challenges to the child's sense of reality and anxiety about whether he/she or the offender will be believed. Even if the offender admits and is willing to seek treatment, he should be asked or ordered to leave until a clinical decision is made that he should return. This action decreases opportunities for the offender to minimize the abuse and to manipulate the child and other family members into feeling sorry for him, placing responsibility for his abusive behavior on others or circumstances, and minimizing the damage to himself.

However, an additional condition for keeping the victim in the home and removing the offender is the mother's support of the child, her ability to resist pressures from the offender, and her more general ability to handle stress related to sexual abuse and its disclosure. Finally, if the victim wants to be removed, this wish should be honored.

Appendix B provides a sample protocol for risk assessment.

TECHNIQUES FOR THE CHILD INTERVIEW AND A METHODOLOGY FOR SUBSTANTIATING SEXUAL ABUSE

Because of the central role played by the child interview in substantiating sexual abuse, it is addressed in greater depth than some of the other aspects of child sexual abuse practice.

INTRODUCTION

As noted in the previous chapter, child interview data may be gathered in one or more interviews, depending on the particular child, the professional conducting the interview, and the safety of the child's living arrangement. The interviewer must initially spend time getting to know the child. This allows the interviewer to learn about the child's life circumstances and possible context of abuse and to ascertain the child's developmental level, modes of communication, the child's affective or emotional state(s), and overall functioning, including the child's competency. With young children, this part of the assessment usually involves play activity with some questions. With older children, the interviewer is likely to rely primarily on talking to the child and asking questions. At this point, questions are usually about the child's life in general and are neutral. They might include queries about the child, as well as her/his school, friends, and family.

Either before, during, or following this general discussion, the interviewer speaks to the child about why she/he is being seen and how the information the child gives will be used. If the interview is to be taped or there are people behind the one-way mirror, the child should be informed. This material is communicated at the child's developmental level and varies with the circumstances of the case.

Information elicited, statements recorded, and behavior observed during this initial phase of the interview often lead naturally into discussion of possible sexual abuse.

TECHNIQUES FOR INTERVIEWING THE CHILD

A variety of techniques can be used in trying to elicit information from the child. The focus here is on techniques most useful with young children. Appropriate questions and several types of media or props—anatomically explicit dolls, anatomical drawings, picture drawing, and story telling, and the doll house—are discussed.

Although appropriate questions will be the first technique discussed, they are no more important than the media that will be described. In many cases, what children demonstrate with media is far more compelling than what they say. It is also somewhat artificial to treat questioning as a separate undertaking. Although questions can be used by themselves, as will become clear, questions are always asked in the process of using media, and the limited research suggests children communicate more accurately when questioned using props than when questioned without them.

It is a good practice to use more than one technique in eliciting information, even if it is only the combination of the use of anatomical dolls and questions. Some of these techniques, such as story telling, are rightfully

the province of mental health professionals and should not be used by Child Protective Services (CPS) caseworkers and law enforcement personnel. However, the other techniques can be used by all professionals likely to interview children, provided they have adequate training in their use.

Use of Questions

It is prudent to avoid leading questions in case they might cause a false accusation and in order to preclude challenges to interviewing techniques. The interviewer should assume that the more open-ended the question, the greater confidence he/she should have in the child's responses. A continuum consisting of five types of questions, from most open-ended to most close-ended, is presented in the following discussion. This framework is fairly consistent with other clinical writing on questioning strategies.[74 75] The types of questions are as follows:

- general questions,
- focused questions,
- multiple-choice questions,
- yes-no questions, and
- leading questions.

General Questions

General questions are frequently used as opening questions when an adult comes in for assessment or treatment. For example, if an adult rape victim comes to a mental health professional, the therapist might begin by asking, "Tell me why you came to see me today." This question is likely to elicit an account of the rape.

Interviewers attempting to determine if a child has been sexually abused usually ask comparable general questions early in the interview. They might ask, "Did anyone tell you why you are coming to see me today?" With adolescents and late latency-aged children, general questions often produce some information about sexual abuse. Unfortunately, these general questions are less useful with young children. Typical responses from them are, "No," or "I don't remember" (despite the care the accompanying adult might have taken in preparing the child). Alternatively young children may acknowledge that they know why they are being interviewed but say they don't want to talk about it. The children may also give vague responses such as "to talk about the bad things" or "to say what Grandpa did." However, they may fail or refuse to elaborate. More directive questions are needed.

Focused Questions

Clinical experience suggests focused questions are optimal. They often elicit relevant information, but they are not leading. There are three types of focused questions:

- questions focused on people,
- questions focused on the circumstances of the abuse, and

- questions focused on body parts.

Within each type, questions focused on daily routine and care activities may produce important information. For example, questions about bathing may elicit details about the body, the "helping" parent, and the abuse setting.

Questions focused on persons will include questions about the alleged offender. It is a good strategy to begin by asking questions that will not be difficult. Thus, focused questions might first be asked about siblings, then about the mother, and finally about the alleged offender. A series of focused questions about an alleged offender might be the following:

- "Where does Joe (mother's boyfriend) live?"
- "What kind of things does he do with the family?"
- "Are there things he does especially with you?"
- "Are there things Joe does that you like?"
- "Are there any things he does that you don't like?"
- "Does he ever do anything with you that you don't like?"

There are two types of focused questions about the possible circumstances of the sexual abuse that many interviewers use.

- "Are there any secrets in your family?"
- "Does _____ ever play games with you?"

These questions are commonly used because often children are told that the sexual abuse is a special secret between themselves and the offender. Alternatively, offenders may induce children's cooperation or normalize the behavior by defining the victimization as a game.

However, there are other potentially productive focused questions related to the circumstances of the abuse. These questions are suggested by the information the interviewer gathers before seeing the child. Examples might be as follows:

- "What do you do when Grandpa babysits?"
- "How does Daddy take care of you when Mom is at work?"
- "What happens when you are in the bath?"

Questions that focus on body parts are generally used in conjunction with anatomically explicit dolls or anatomical drawings. The interviewer has the child give names for the various body parts. Then focused questions can be asked. For example, the interviewer might ask the following questions with regard to the penis:

- "Did you ever see a 'dinky' (penis)/anybody else's 'dinky'?"
- "Whose did you see?"
- "What does a 'dinky' do?"

If the child responds, "It goes 'pee'," the interviewer might ask,

- "Does it do anything else?"

Comparable questions might be asked of a female victim about the vagina:

- "Did you ever see anyone else's 'peepee'?"
- "Did anyone ever ask you to touch their 'peepee'?"
- "Did anything ever happen to your 'peepee' that you didn't like?"
- "Does it ever hurt?"
- "What makes it hurt?"
- "Does anyone ever touch it?"

If the child responds that she touches it, the interviewer might ask:

- "Does anyone else touch it?"

If the child names someone, the evaluator might follow with:

- "When does he touch it?"

In some cases or at certain points during an interview, children may not respond to focused questions, or they may reply, "I don't know," or "I don't remember." In these cases, more directive questions are necessary.

Multiple-Choice Questions

When information is not forthcoming with a focused question, the interviewer may resort to a multiple-choice question. There are several caveats for their use. First, young children may have difficulty with this format, and they will have more difficulty the more options given. Second, interviewers must be sure to include a correct response, so that the child is not given the choice between two or more incorrect responses. Thus, in a case in which the victim has affirmed that another child was there, but did not respond when asked who it was, the interviewer might ask, "Was it one of your friends or someone else?" in case it was someone the child did not know. Third, it is advisable to limit the use of multiple-choice questions to the circumstances of the sexual abuse and, if possible, not to use them to ask about the abuse itself. For example, the interviewer might ask:

- "Do you remember if you were wearing your day clothes or your night clothes?"

The interviewer would avoid asking:

- "Was it your dad, your stepdad, both, or someone else who hurt your butt?"

Yes-No Questions

Despite the fact that research indicates that even young children provide quite accurate information in response to yes-no questions,[76] they are generally used in investigative interviews only when more open-ended questions are not productive, but the interviewer continues to have concerns about abuse. The reason for reservations about yes-no use is concern that they may elicit "social desirability" responses, especially in young children. That is, the child may answer in the affirmative because she/he thinks a positive response is desired. Alternatively, the child may not understand the question and nevertheless answer yes.

Unlike focused questions, yes-no questions usually identify both the alleged offender and the sexual behavior in question. (Focused questions, except those about the circumstances of the abuse, contain one or the other.) Examples of yes-no questions are as follows:

- "Did your mom put her finger in your vagina?"
- "Was it your stepfather who made your 'bum' (anus) bleed?"

Leading Questions

A leading question is one in which the desired answer is specified in the question. Leading questions are commonly encountered by witnesses when they are cross-examined in court. However, they are not appropriate to investigative interviewing of children. Leading questions are usually not necessary and may be perceived as coercive because they convey the interviewer's own view of events. Interrogations using leading questions also may influence children's interpretations of events[77] and are likely to lead to an attack on the validity of the interview findings. Examples of leading questions are as follows:

- "Your dad sucked your penis, didn't he?"
- "Isn't it true your grandmother told you to say your stepdad put his 'dick' in your sister?"

Strategic Use of Questions

The interviewer should use as many open-ended questions as possible. That is, the interviewer endeavors to use general or focused questions and only resorts to multiple-choice or yes-no questions if the former are not eliciting any information. As more close-ended questions are employed, it is prudent to have less confidence in the replies. When information is elicited in response to, for example, a multiple-choice question, the interviewer then reverts to a more open-ended approach, perhaps asking a focused question.

The following series of questions is illustrative: The interviewer asks the child where mom was when the abuse occurred (a focused question), and the child does not reply. The interviewer then asks whether mom was there or not (a multiple-choice question). The child replies that mom was there. The interviewer then asks, "What was she doing?" (a focused question). The child responds, "She was helping my dad." The interviewer then asks how the mom helped (another focused question). The child says, "It's hard to say." The interviewer responds, "Well, did she do any of the touching?" (a yes-no question). The child nods. The interviewer then asks where the mother touched (a focused question).

For a chart that illustrates the continuum of questions, see Appendix C.

Use of Anatomically Explicit Dolls

Anatomical dolls are the most widely employed of the media.[78] Although most appropriate for use with children aged 2 to 6, anatomical dolls may be used with children of any age. In this section, the challenges to the dolls, their advantages, and techniques for their use will be discussed.

Challenges to Anatomically Explicit Dolls

The dolls have been challenged, generally by defense attorneys and their expert witnesses, as being "leading," that is, triggering allegations of sexual abuse because they are "suggestive." However, research indicates that they do not elicit sexual responses from children who do not have prior sexual knowledge,[79] [80] and in the few studies that compare the responses of children believed to be sexually abused to those of children not so found, the former are significantly more likely to engage in sexualized behavior with the dolls than the latter.[81] [82] However, many children believed to have been sexually abused do not engage in sexualized behavior with the dolls.

Nevertheless, a definitive determination of sexual abuse is made not merely on the basis of what the child does with the dolls. Children may learn about sexual activity in ways other than being abused, for example, from consensual involvement with peers, from viewing erotica or pornography, or from sex education classes. Therefore, if the child spontaneously demonstrates sexual activity with the dolls, the interviewer needs to ask questions to clarify the source of the child's knowledge.

That is, if a child puts the penis of the adult male doll into the vagina of the female child doll, such behavior is certainly suggestive but not conclusive. In response to such a demonstration, the interviewer might ask, "Who does that?" in order to find out whether or not the child has been sexually abused.

In addition, anatomically explicit dolls have been criticized because they have not been subjected to the validation process employed with psychological tests. As noted above, there have been studies employing the dolls with general populations of children and a small number of studies that compare the responses of children assumed to have been sexually abused to those assumed to have not been abused.[83] However, the dolls are not meant to be a psychological test, any more than Barbie™* dolls are. Rather, they are a medium through which interviewers may communicate with children, just as language is.

Advantages of Anatomically Explicit Dolls

The dolls are not a magical instrument that makes disclosure of sexual abuse automatic. In addition, the small number of studies comparing anatomical dolls to other media, for example, regular dolls, suggest thus far no particular superiority of the dolls over other media. However, the advantages noted by clinicians include:

- For young children, the dolls may be a more familiar medium than speech, and often one in which they are more accomplished, because children generally interact with toys, including dolls, before they have a lot of language.

---

* Barbie ™ is a registered trademark of Mattel, Inc.

- The dolls' explicit parts may serve as a stimulus to remind the child of sexual abuse.

- Their genitalia, breasts, mouth openings, and anal openings allow for more precise communication than speech or nonexplicit dolls.

- For many children, who actually have the language to communicate, showing what happened with the dolls may be easier than telling.

How to Use Anatomically Explicit Dolls

There is no scientifically demonstrated right or wrong way to use the dolls. Everson and Boat[84] have reviewed the various guidelines for using anatomical dolls and have determined that there are five different functions they may serve—comforter, ice-breaker, anatomical model, demonstration aid, or memory stimulus. The most commonly endorsed functions are as an anatomical model, as a demonstration aid, or as a memory stimulus.

When the dolls serve different functions, they may be used in different ways. Three methods of using the dolls and the functions they serve are described.

Scenario in which the child spontaneously engages with the dolls. Some interviewers have the dolls available in the room with their clothing on. Children will sometimes pick up the dolls and begin playing with them. Depending on the stage of the interview, the interviewer may encourage the child to examine the dolls more closely. This process may involve the use of several dolls, usually four, and may include identifying them by gender and whether adult or child, undressing them, and identifying body parts, including the private body parts. In this process, the dolls may serve as a memory stimulus.

The interviewer may interpret unusual reactions to the dolls, for example, marked fear or sexualized behavior, as indicative of possible sexual abuse, and will want to pursue these reactions further. The child might be asked why seeing the doll caused her/him to be so upset. If sexualized behavior was noted, the child might be asked who does that and additional questions about the acts the child has demonstrated.

Similarly the sight of the genitalia on the dolls may serve as a memory stimulus and result in a statement about sexual abuse or something indicating advanced sexual knowledge. Again the interviewer will pursue these leads by asking for specifics and further information.

When the mere sight of the dolls with genitalia does not lead to any information, the interviewer may use them as an anatomical model. Using the names the child has given for the genitalia, the interviewer asks questions about the dolls and their genitalia. Below are sample questions about the penis and possible responses. It is important that the interviewer have in his/her repertoire a range of ways to approach the child, but the interviewer should allow the child ample time to respond and avoid a barrage of questions.

- "Who has a 'dingdong'?" "Did you ever see one?" "Whose did you see?" "Does anything ever come out of the 'dingdong'?" If the child responds yes, "What color is it?" If the child says white, milk, or like snot, "Did any ever get anywhere on or in you?"

- "Did anyone ever try to do something to you with a 'dingdong'?" "What did he try to do?" "Can you show me with the dolls?"

- "Did anyone ever want you to do something to or with his 'dingdong'?" "Can you show me with the dolls what he wanted you to do?" "Did you have to do it?"

- "Do you know what a 'dingdong' feels like?" "Does it ever change?" "Does it ever get bigger?" "Is it hard or soft?" "Is it hanging down, or does it stick up?" "Can you show me with the dolls how it goes?"

Similar questions can and in many cases should be asked about other genitalia and the anus. However, caution should be used in asking questions about erections, semen, and how the semen tastes when there is no independent information that the child is likely to possess such knowledge. This will avoid a circumstance in which the interviewer introduces the child to advanced sexual knowledge.

In cases in which the child spontaneously picks up the dolls, they can be used somewhat differently as an anatomical model as follows: rather than asking children about their own experiences, once the dolls have been undressed, children can be asked what might have happened to the doll, or the doll can be named (using a name other than the child's) and then questions asked about its experiences. This may make the discussion less threatening. Thus, instead of asking a female victim about her own vagina, the interviewer might ask about "this girl's 'peepee'." If positive information is elicited, it is important to ask if something like that happened to the child and, if so, with whom.

Comparable questions can be asked about the naked dolls, rather than their parts. Examples might be:

- "What do they do when they have their clothes off?" inviting the child to demonstrate.

- "Do the mom and dad ever do anything when they're naked?"

- "Show me how they take a bath."

- "Does the daddy ever do anything to the girl when she's naked?" If the child affirms, "Can you show me that?"

Again, the interviewer must ascertain that the child is speaking about her/his own experience if the child reveals any knowledge of sexual activity.

Scenario in which the dolls are introduced during the discussion of sexual abuse. Another way the dolls can be used is during the course of verbal disclosure. In this instance, the dolls are used as a demonstration aid. There are several circumstances in which they can be used in this manner. If a child is saying, "I don't want to talk about it," the interviewer may ask the child if she/he prefers or would find it easier to show. Second, the dolls may be used to clarify or obtain more detail about a verbal disclosure, for example, what exactly "humping" is. Third, the dolls may be used as a medium to corroborate the child's verbal statements. It is especially important, with children who are 2 to 6 years old, to get them to clarify or corroborate any verbal disclosures with the dolls. With children aged 6 and older, the evaluator may ask if they prefer to show what happened with dolls, draw a picture, or tell about it.

To introduce the dolls, the interviewer may say to the child that she/he has some dolls that are a little bit different. The interviewer may then select relevant dressed dolls and might ask the child if she/he has ever seen dolls like these before, as they are undressed. Alternatively, the evaluator may introduce one doll, undressing it to show the child how the dolls are different, and then have the child choose the dolls to use to "show what happened". Children may demonstrate by using two (or more) dolls, or they may use the doll and their own bodies.

For example, one 3-year-old girl, when asked to show how Daddy hurt her, using the dolls, picked up the naked adult male doll and thrust his penis into her crotch, saying "unh, unh, unh."

In such a situation, questions can be asked to obtain specific detail, such as:

- "Can you show me how far his 'dick' went into your mouth?" "Did anything come out of his 'dick' when he did that?"

- "Do you remember what room you were in?" "Were you on the bed or somewhere else?" "Can you show how he did it?"

Some children will not respond when asked to use the dolls to demonstrate the alleged abuse. The interviewer then may proceed to less spontaneous approaches. For example, the child may be asked to point to the place on the child doll where something happened to her/him, and if the child does point, then the child may be asked what exactly happened. Similarly, the interviewer may ask the child to point to the part of the adult doll's body that was used in the encounter, assuming some sort of an encounter has been affirmed. If the child designates a body part, the child is then asked to demonstrate exactly what happened.

Finally, if no information is forthcoming from the approaches already described, the interviewer can ask the child if she/he will answer "yes" or "no" if the interviewer points on the child doll to the parts of the child's body that might have been involved. Alternatively, the interviewer can use the adult male doll to ask the child to reply "yes" or "no" to the parts of the alleged offender's body that might have been involved. These are yes-no questions and therefore fairly close-ended. It is advisable to point to some body parts very unlikely to be involved in order to test for possible "social desirability" responses. If confirming information is elicited, then, of course, the interviewer reverts to more open-ended questions.

Scenario in which the dolls are introduced without any cues. Finally, the dolls can be introduced independent of any opening by the child. If no opportunities for a discussion on sexual abuse have arisen, some professionals will introduce the dolls toward the middle of the interview. However, others prefer to introduce the dolls rather early to elicit material about possible sexual abuse. When used in this manner, the dolls may serve as a memory stimulus or a diagnostic screen, but their major use is as an anatomical model.

Some professionals use the dolls to assist in identifying private (where it's "ok" to touch yourself in private, but where others should not touch you) versus other body parts, or good and bad touch areas. Sometimes touch is differentiated as good (e.g., a hug) bad (e.g., a slap), and trick—which feels good but is bad because it is in a private area. Then the child is asked about any experiences of touching in the private area or bad or trick touching.

Objections have been raised to the concept of good and bad touch, and it may be advisable to avoid using this concept for three reasons. First, the term "touch" is confusing to young children and may foreclose consideration of some types of activity (e.g., licking and object or penile intrusion). Second, the terms, "good" and "bad" may be too vague in that they do not connote the actual body parts. Third, the use of good and bad to refer to breasts, genitalia, and anus may lead to negative perceptions of the private body parts. However, these views of good and bad touch represent professional preference. There is no evidence that the use of the "good touch/bad touch" approach either contaminates or invalidates an interview.

Use of Anatomical Drawings

Anatomical drawings are pictures of adults and children, males and females, at different developmental stages— elder, adult, adolescent, latency age, and preschooler, without clothing and with primary and

secondary sex characteristics. These drawings may have the frontal position presented on one side of the page and the dorsal on the other.[85] They are used like skin maps; therefore, relevant pictures are used for each child interviewed.

In many respects, the use of anatomical drawings parallels the use of anatomically explicit dolls. Anatomical drawings are useful with the same age range of children as the dolls; they are particularly useful with very young children but also appropriate with older children. Appropriate pictures are chosen by either the child or the interviewer. The child can be asked to mark on the drawing or point to the part on the drawing that was involved.

The disadvantage of pictures is that it is more difficult for the child to enact any sexual behavior with pictures. However, children may make clothing for the pictures in order to demonstrate how clothing was removed, put one drawing on another to show "humping" (intercourse), and draw arrows and lines between genitalia in order to indicate intercourse.

On the other hand, anatomical drawings have the considerable advantage of being a permanent, visual record. They become part of the interviewer's case record and, as such, are admissible in court. In addition, the drawings have not been challenged as the anatomical dolls have.

Because of the potential use of drawings as evidence, it is advisable for professionals to put as much information as possible on the drawings. Professionals should have the child write the name of the person whom the particular drawing represents, if the child can do so. If the child cannot write, the interviewer should write the name. The interviewer should encourage a child to write or draw on the pictures to illustrate aspects of the abuse. For example, if the child indicates the offender used a finger to hurt her vagina, the interviewer should have her circle or mark the appropriate finger(s), and then the child or the interviewer should write beside the finger that it is the one that went in her vagina. Professionals should write on the picture the questions asked and the child's responses. For example, in a situation involving sexual abuse in day care, a 4-year-old girl marked the penis, the head, and the feet on the anatomical drawing representing her little brother. These were the places "the teachers did bad things." Beside each of the child's marks was written "a place the teachers did bad things." The questions and the child B's whispered responses were written beside the penis on the picture representing B's brother:

Int.: "Who did something to his penis?"

B.: "Miss Rose."

Int.: "What did she do?"

B.: "Bit it."

Int.: "How do you know?"

B.: "I saw her."

Use of Picture Drawing

Although a few clinicians have made observations about the characteristics of drawings of sexually abused children,[86,87] there has been no systematic exploration of their content. Nevertheless, many types of pictures can be helpful. Drawing is most useful as a diagnostic technique with latency-aged children. However, children as young as age 4, and in some cases 3, can produce useful drawings as long as the various items in

the picture are labeled and explanations are written on the picture. Some adolescents will prefer to draw a picture of what has occurred rather than to describe it verbally.

Drawing can have uses other than gathering information about possible sexual abuse. For instance, drawing can be employed to reduce tension, to understand issues other than sexual abuse, and to assess the child's overall functioning.

The interviewer may employ pictures either indirectly or directly to gather information that may be related to the child's victimization. Asking the child to draw any of the following pictures may indirectly result in findings:

- "Draw me a picture of anything."
- "Draw me a picture of yourself."
- "Draw me a picture of a person."
- "Draw me a picture of your family."
- "Draw me a picture of your family doing something."
- "Draw me a picture of (possible perpetrator)."

Sometimes sexual content (e.g., genitalia or sexual acts) is noted in the pictures. If this is the case, questions should be asked about this content. The child's responses may provide information about sexual abuse. For example, a 5-year-old child, when asked to draw "anything," drew a picture of "Daddy" with a large "peanuts" (penis). When asked what the "peanut" was and if she had ever seen one, she eventually described her father taking her into his bed and fondling her as he fondled himself.

Alternatively, asking the child to talk about the picture may elicit information about abuse. For example, the interviewer might ask what is happening in the picture or what makes the person in the drawing happy, sad, angry, and scared. A 5-year-old drew a picture of her mother and her mother's boyfriend and then scribbled over the drawing. When asked what they were doing, she indicated the scribbles meant they were having sex.

If the child fails to provide any information about sexual abuse in response to queries about drawings, then caution should be exercised in their interpretation. Although the specifics of the pictures and other information about the case must be taken into account, pictures of genitalia do not necessarily mean the child has been sexually abused, and a sad drawing could have a wide range of significance.

The following drawing requests are aimed at gathering information directly and may be used when the child has already indicated something happened.

- "Draw me a picture of (identified perpetrator)."
- "Draw me a picture of where (the abuse) happened."
- "Draw me a picture of what (the perpetrator) did."
- "Draw me a picture of the (instrument/body part) he used."

These requests may be used when children are having difficulty disclosing, when there is a need to clarify what the child has said or demonstrated, or when the interviewer wants to corroborate disclosures using the medium of drawing.

To facilitate disclosure, the interviewer may ask the child if she/he would rather draw when the child says she/he doesn't want to talk. Further, if the child claims not to remember very much, asking the child to draw the location of the alleged abuse may trigger recollection of detail and free the child to discuss the abuse.

Drawings that may be particularly helpful for clarification are pictures of what the offender used (instrument or body part) and of what happened. A 5-year-old with vaginal injury referred to an instrument used in her abuse as "Daddy's stick" but could not give further detail. The police officer interviewing her asked her to draw it, and she drew what appeared to be a ruler. Her mother was able to say where in the house it would be found, and the officer got a warrant and seized the physical evidence.

Like anatomical pictures, the child's drawings become part of the case record and can be submitted into evidence. Therefore, the interviewer should have the child label various parts of the drawings and write relevant comments. Again, if the child is unable to do this, the interviewer should label the drawings.

The Dollhouse

Very little has been written about the use of the dollhouse in interviewing children alleged to have been sexually abused. Nevertheless many mental health professionals and some CPS workers use it in investigative interviewing. It is especially useful with preschoolers.[88]

Larger dollhouses, with sturdy furniture and people 3 to 6 inches tall, are optimal. The bigger the people, the easier it will be for the child to show activities and for the interviewer to see them. Most dollhouse people do not have removable clothing, which makes it difficult for the child to demonstrate some sexual abuse. However, the dollhouse provides a better opportunity to address the issue of the context of the sexual abuse than most other media.

Like drawings, dollhouse play can have goals other than data gathering about possible sexual abuse. For example, dollhouse play can be used to get to know the child and to understand something about how the child generally perceives families and family activity. And again like drawings, the dollhouse can be used indirectly and directly to gather information about possible sexual abuse.

Indirect use could involve observing the child's dollhouse play and then commenting or asking questions when themes possibly related to sexual abuse are present. For example, the child might repeatedly have the little girl doll going to bed with the adult male. The interviewer might ask what is happening when they go to bed.

The interviewer might use the dollhouse more directly to gather information if he/she has some background about the context of possible abuse. In a case involving a little girl who had just turned age 3, the mother thought the father had inserted something into the child's vagina one evening when the mother was lying ill on the couch and the father gave their daughter a bath. During the second session with the child, the interviewer structured the dollhouse situation so the mother doll was on the couch, the little girl doll in the bathtub, and the father in the bathroom. When the child approached the dollhouse, familiar to her from the previous session, she froze and began to shake. Later she demonstrated sexual abuse by her father.

Other examples of using contextual information might involve setting up a scenario around bedtime or watching television and then asking the child to show what happens at bedtime or TV time and other relevant questions.

RESEARCH ON THE RELIABILITY AND SUGGESTIBILITY OF CHILD WITNESSES

Along with other challenges to allegations of sexual abuse have come challenges to the credibility of children as witnesses. Questions regarding the accuracy of their memories and their suggestibility have been raised.

Fortunately for professionals concerned about the sexual abuse of children, these questions have been addressed through a series of experiments that simulate some of the circumstances of sexual abuse. In general, these studies indicate that children can remember and that they are resistant to suggestion.

Children's Memories

Older children have more complete recall than younger children. However, studies indicate children as young as 3 years old can recall experiences comparable to those found in sexual abuse. Young children remember fewer details and recall central rather than peripheral events when compared to older children.[89] Moreover, although children may not volunteer information about concerning events (a genital exam) or traumatic events (an inoculation or having blood drawn),[90] similar in some respects to sexual victimization, such events are recalled as well by children as adults.[91] Children's ability to provide accurate accounts appears to be facilitated by the availability of "props," such as anatomically explicit dolls, regular dolls, and anatomical drawings.[92 93] As noted in the discussion of appropriate questions, children may require fairly direct questions in order to provide information. Children's memories will fade over time, but their recall can be enhanced by periodic recall of the events in question.

Children's Suggestibility

The research indicates that most children are resistant to giving false positive responses to leading and suggestive questions. When they do provide false positives, they are generally limited to a nod or a simple "yes." Older children are more resistant to suggestion than younger ones.[94] Children are much more likely to deny actual experiences, which are perceived as traumatic or unacceptable, than to make false assertions about events that did not occur.

However, one study found that children are suggestible, not with regard to factual data but as to the interpretation of the facts. In a study involving 75 children, Clarke-Stewart had a cleaning man interact with toys. In one condition, the man described his activities as cleaning and in the other as playing. The children were then interrogated by an interviewer who pressured the child to interpret the man's behavior as either cleaning or playing. The researchers found that children did not change their statements regarding what had actually taken place, but most children were highly influenced by the interviewer's interpretation of the cleaning man's acts (cleaning versus playing). The implications of this study are clear. They reiterate the importance of using open-ended questions as much as possible and caution professionals to be careful about interpreting behavior, especially child care behaviors.[95]

Criteria To Be Used To Substantiate Sexual Abuse

Once data have been gathered from the child interview and other sources, the interviewer must decide whether, in her/his opinion, the child was sexually abused. A number of writers have addressed this issue.[96 97 98 99 100 101 102 103 104] All of these authors are of the opinion that substantiating information

must go beyond affirmative responses to one or two questions, and most suggest some combination of descriptive detail and emotional reaction to the content. Indeed, there is a fair amount of consensus among these writings about the characteristics of a true account of abuse.

However, there has been very little research on the extent to which these clinical criteria are actually present in true cases, in large part because it is so difficult to isolate cases that are proven to be true. The criteria developed by Faller[105] will be presented here because there is one research study that examines the extent to which they are found in cases substantiated by offender confession, because they are parsimoniously organized, and because they are fairly consistent with the criteria developed by other writers.

There are three general categories of information that should be assessed in the child's statements and/or behavior:

- a description (either verbal or behavioral) of the sexual behavior;
- information about the context of the sexual abuse; and
- an emotional reaction consistent with the behavior being described, the child's functioning, and the circumstances of the interview.

A Description of the Sexual Abuse

In assessing the child's description of the sexual activity, the interviewer is looking for:

- sexual knowledge beyond that expected for the child's developmental stage;
- an account consistent with a child's perspective; and
- an explicit description of the sexual acts.

Advanced sexual knowledge and a child's perspective are, of course, more persuasive findings with younger children. An explicit account is relevant for children of all ages.

Information About the Context of the Sexual Abuse

Information about the context of the sexual abuse might include:

- where it happened;
- when it happened;
- where other people in the family were;
- what the offender might have said to involve the child;
- what the victim and offender were wearing and what clothing was removed;
- the frequency and/or duration of the abuse;

- whether the offender said anything about telling or not telling;
- whether the child told; and
- if so, whom did the child tell and that person's response.

The child may have been sexually abused many times and, therefore, may not remember details about all instances. It is best to ask the child to tell about the last time in order to obtain contextual information. In the research on these criteria, the child was considered to have provided sufficient contextual material if she/he gave three pieces of contextual information.

Preschool children will probably have a hard time focusing on and describing the most recent incident. In addition, they will not have the ability to abstract and say, for example, "Sometimes it happened in the bathroom, at other times in the basement, and once at my grandmother's house." As a consequence, their accounts of the context (and the abuse, itself) may be confusing and apparently inconsistent. What may be happening is the child may be recalling different incidents when being questioned at different times or by different people. These problems may occur when preschool children are interviewed by different people and/or at different times, or when they recount two or more different incidents, or parts of them, in the same interview.

An Emotional Reaction Consistent With the Abuse Being Described

Children may have a variety of emotional reactions to sexual abuse, depending on the characteristics of the child and the abuse. The following are common emotional reactions and associated child or abuse characteristics:

- reluctance to disclose: characteristic of most children except possibly for very disturbed or very young children;
- embarrassment: a rather mild response often found in disturbed and young children;
- anger: more characteristic of boy victims (but not always evident);
- anxiety: noted frequently in adolescent girls;
- disgust: a typical reaction to oral sex;
- depression: often present in victims who care for the abuser or feel they are responsible;
- fear: typical of cases in which the child has been injured or threatened during the course of the victimization; and
- sexual arousal: another response sometimes found in disturbed and young children.

Situations In Which the Clinical Criteria May Not Be Found

The small number of studies that examine clinical criteria in proven cases (which are usually substantiated with offender confession) find that a substantial number of children's accounts lack the expected criteria.[106 107 108] For example, in Faller's study, only 68 percent of accounts contained all three criteria. Young age

of the victim and being a boy were associated with not satisfying the expected criteria. Younger children were less likely to provide contextual detail and to evidence an emotional response consistent with the account. Similarly, boy victims were less likely to describe the abuse and to exhibit affect.

There can be other good reasons why children fail to manifest the expected clinical criteria. Affect may be absent because the child dissociates, the child has told about the abuse many times, or the trauma has already been addressed in treatment. In addition, emotionally disturbed children, who have suffered many other traumas, may not become upset about sexual abuse because, compared to their other life experiences, it is not as bad. Detail may be absent because the abuse has been repressed or because it happened long ago and has been forgotten.

It is legitimate to substantiate a case with only a description of the sexual abuse.

Moreover, it is important for interviewers to appreciate that a child's inability to describe sexual abuse does not mean it did not happen. It means that sexual abuse cannot be confirmed, but that is different from it not having happened. Research on adult survivors indicates that many victims never tell.

Criteria for Confirming an Allegation From Other Sources

There are other sources of information that can support a finding of child sexual abuse.

Suspect's Confession

The most definitive finding is the suspect's confession. Unfortunately it is uncommon, particularly at the point of investigation, when the alleged offender may be very frightened and concerned primarily with his own well-being.

An operational definition of a full confession is that the alleged offender admits to all or more sexual activity described by the child. As a partial confession, the suspect may make "incriminating" statements by admitting to some but not all of the child's allegations. Alleged offenders may minimize their behavior by admitting to "just touching," may deny acts involving severe penalties, or may not admit to certain behavior they find particularly shameful. These incriminating statements deserve attention because they may be found in cases in which the suspects are frightened to admit. There appear to be several types:

The alleged offender may claim diminished capacity.

- "I don't remember what I do when I've been drinking."

The suspect admits to the behavior but says it was not intended to be sexually abusive. There are actually two types of cases that fall within this category, those in which the suspect says the mistake was on his part and those in which he insists his behavior has been misinterpreted. Examples follow:

- "I forgot my daughter was in the bed with me. I thought she was my wife."

- "I was only trying to show her the difference between men's privates and little girls'."

The evaluator must use common sense in assessing the probability that the alleged offenders' explanations are likely and feasible. There will be cases, especially those involving child care activities, where this is quite difficult.

In addition, the suspect may admonish professionals to attend to the accounts of others.

- "My daughter would never lie about a thing like that."

Finally, the alleged offender may say that he didn't abuse the child, but he is confessing to it to get on with treatment or to keep his daughter from having to testify against him in court.

Medical Evidence

As noted in the previous chapter, there has been considerable progress in the documentation of physical findings from sexual abuse.

Other Physical Evidence

In some cases, the police and sometimes others will have obtained physical evidence such as pornography or instruments used in the abuse.

Eyewitnesses

Occasionally, there will be eyewitnesses to sexual abuse. These may be other children who were also abused or who observed abuse. They may also be adult eyewitnesses, sometimes the spouse of the offender.

Forming a Conclusion About Sexual Abuse

In order to arrive at a conclusion about the likelihood of sexual abuse, the professional weighs the clinical findings from the child's interview as well as confirming evidence from other sources. Rarely is the professional 100-percent sure that the abuse occurred as described, with absolutely no room whatsoever for doubt. On the other hand, it is extremely difficult to determine without any doubt that the sexual abuse did not occur. In this regard, Jones has developed a useful concept, a continuum of certainty. Cases fall somewhere along a continuum from *very likely* to *very unlikely*.[109]

For guidelines that can be used to establish the likelihood of an occurrence of sexual abuse, see Appendix D.

TREATMENT OF CHILD SEXUAL ABUSE

Treatment of child sexual abuse is a complex process. Orchestration of treatment in the child's best interest is a genuine challenge. Moreover, it is often difficult to know how to proceed because there are so few outcome studies of treatment effectiveness.

In this chapter, case management issues are discussed; a model for understanding why adults sexually abuse children is proposed; treatment modalities are described; and treatment issues are examined. The focus of the discussion is primarily on intrafamilial abuse.

CASE MANAGEMENT CONSIDERATIONS

One of the reasons sexual abuse treatment is such a challenge is that it occurs in a larger context of intervention. Therefore, coordination is of utmost importance and ideally is provided by a multidisciplinary team. Treatment issues are then handled by the team as part of overall intervention.

The team usually consists of the various professionals directly involved in the case and their consultants and, as noted earlier, begins its activity at the time of case investigation. The composition and functioning of teams vary by locality, and the level of participation of team members often varies depending on the stage of the intervention. In an intrafamilial case, the members active at the treatment stage will ordinarily include the Child Protective Services (CPS) and/or foster care workers, the therapists treating various family members, professionals providing other services (e.g., homemaker, parenting guidance), a representative from the prosecutor's office, and relevant consultants. The frequency of meetings will depend on the needs of the case and how the team is structured.

The following issues are the most important of those the team should consider at this stage of intervention: separation of the child and/or the offender from the family, the role of the juvenile court, the role of the criminal court, the treatment plan for the family, visitation, and family reunification.

Case management decisions are often provisional; that is, they are based on what information about the family members and their functioning is available when decisions are made. Treatment is often a diagnostic process. The positive or negative responses of family members to treatment determine future case decisions. Outcomes of court proceedings can impinge upon and alter case management decisions and treatment.

The team meets periodically to assess progress and make future plans. Because of the complexity of case management decisions and the fact that a decision in one realm can have an impact on other aspects of the case, especially on treatment progress and outcome, multidisciplinary decision making is crucial. In the absence of a multidisciplinary team, such decisions should be made in consultation with other relevant professionals.

Before the implementation of the treatment plan, the following case management decisions should be addressed:

- Should the child remain a part of the family?
- Do the courts have a role in the case?
- Is there a question of visitation?

Guidelines for making these decisions will be discussed.

Should the Child Live With the Family?

The preferred outcome in cases of sexual abuse, as in other types of child maltreatment, is that after intervention the family will be intact.

Generally at the time of disclosure of the sexual abuse, the offender is not separated from the family. The victim may be removed if the mother is unable or unwilling to protect and support the victim or if the victim wishes to be removed. Many professionals advocate the removal of the offender even in circumstances in which the victim is removed.

After these initial decisions, a longer term plan must be made about whether the child should be a part of the family and, if so, whether or not that family should include both parents. This plan will be based on an assessment of each parent.

Aspects of the functioning of both parents outlined previously in the discussion of risk assessment should be examined in deciding about the child's future living situation. These include the following factors for the offender:

- the extent of the offender's sexually abusive behavior;
- the degree to which the offender takes responsibility for the sexual abuse;
- the number and severity of the offender's other problems, for example;
  - substance abuse,
  - violent behavior,
  - mental illness, and
  - mental retardation.

Regarding the nonoffending parent, the following factors should be assessed:

- reaction to knowledge about the sexual abuse,
- quality of relationship with the victim,
- level of dependency on the offender, and
- the number and severity of other problems.

Other possible problems are similar for the nonoffending parent and the offender.

Although these factors are universally useful to consider, in specific cases other factors may be important or even overriding.

Offenders who have engaged in a small number of sexual acts, have taken responsibility for their behavior, and have few other problems are judged to have positive findings in these key areas and are usually treatable. Negative findings in these three areas mean that the prognosis for positive treatment outcome is quite guarded.

When mothers are protective of victims when they discover the sexual abuse, have good relationships with victims, are not unduly dependent on the offender, and do not have other significant problems, their treatment prognosis is positive. Again negative findings mean that the treatment prognosis is poor.

These proposed variations in parental functioning suggest four possible combinations: both parents may have positive findings, indicating a good treatment prognosis (case type 1); the nonoffending parent may have positive findings, and the offender negative ones (case type 2); the offender may have positive findings and the nonoffending parent negative ones (case type 3); and finally, both parents may have negative findings (case type 4).[110]

Different combinations argue for different intervention plans and long-term goals. General strategies are suggested in the decision matrix in Chart 3.

Chart 3. Treatment Strategy Decision Matrix

NONOFFENDER	OFFENDER: Positive Findings	OFFENDER: Negative Findings
Positive Findings	***CASE TYPE 1*** Plan for family reunification Ultimate therapeutic intervention will be family therapy 1. Reduce offender's risk to reabuse through treatment and separation (i.e., offender removal from the home) 2. Therapy with nonoffending parent and child(ren) 3. Dyadic and family therapy and/or couple's therapy 4. Reunite family	***CASE TYPE 2*** Separate offender from family 1. Individual treatment for child(ren) 2. Individual treatment for nonoffending parent 3. Therapy for nonoffending parent and child(ren)
Negative Findings	***CASE TYPE 3*** Place child(ren) temporarily Therapy for each parent if this therapy is successful 1. Couple therapy 2. Therapy with nonoffending parent and child(ren) 3. Therapy with offending parent and child(ren); if these are successful: 1. Family therapy 2. Gradual reunification	***CASE TYPE 4*** Remove children permanently Terminate parental rights Therapy for child(ren) Therapy for new caretakers and child(ren)

This matrix suggests how professionals *hope* to be able to make decisions. However, the parents are usually more complex than the matrix suggests. Probably in the majority of cases, the parents present a mixed picture, rather than appearing to have either a very good or bad prognosis. Moreover, as already suggested, there may be gaps in information about the family when treatment planning is undertaken and parental functioning is not static. Progress or lack of progress in treatment may result in reconsideration of the initial placement and treatment plan. Because of these complexities, most sexually abusive families *should* and *do* receive a trial of treatment. This generally entails individual treatment for all parties and the appropriate use of groups. Initial case decisions are periodically evaluated based on treatment outcome and reassessed accordingly.In addition to being useful in placement and treatment planning decisions, the matrix may offer guidance in terms of court intervention. Most professionals would agree that the Juvenile Court should be involved in all four types of cases, perhaps with the exception of a small number of those falling into case type 1. These might be cases in which the offender confesses to his wife or family, the family seeks treatment, and the abuse is then reported to CPS by their therapist.

There is also increasing consensus that criminal charges should be filed, even though the offender appears treatable. Some professionals feel that even treatable offenders should do some jail time, while others see the criminal process as a means of ensuring that the treatable offender will take responsibility for his behavior and/or enter into treatment. However, criminal prosecution is especially important in cases categorized as case types 2 and 4 to offer some protection to both the family and society from the offender.

In addition, factors related to the child should also be considered. These include the child's wishes. To be more precise, if the child does not wish for a reunified family, that desire should be given a great deal of weight. A child's wish for the offender not to leave the home, however, should generally not be granted. In addition, some sexually abused children are so damaged, because of the abuse and other conditions, that they require specialized care outside the home.

The same assumption is made here as in earlier chapters, that there is a single offender, usually a father figure, and a nonoffending parent, usually mother figure. If that is not the case, and there is more than one offender, especially within the family, prognosis is much poorer. Even more problematic are cases in which both parents are offenders; in such instances, family reunification is extremely unlikely to be in the child's best interest.

The Role of the Courts

Two or three courts are potentially involved in a sexual abuse case—the Juvenile Court, responsible for child protection; the Criminal Court, responsible for offender prosecution; and the Divorce Court, if either parent decides to pursue divorce.

Court involvement can be either a help or a hindrance to therapeutic goals. The challenge is to integrate court involvement into the overall intervention. Early decisions about the role of the court can facilitate its role in the therapeutic process.

The court can be helpful in compelling family members, especially offenders, into treatment; in protecting victims and families from offenders; and in effecting alternative living situations for offenders (or victims, if necessary).

Court involvement can be problematic because legal safeguards for the defendant may prevent certain evidence from being admitted; because the adversarial process may interfere with the therapeutic process, including disruption of offender treatment by incarceration; and because it allows procedural delays that may prevent timely intervention.

Finally, testifying in court may have a positive or negative effect on the child. The effect, in part, depends on its outcome. That is, if the case is won, the impact of court testimony is more likely to be positive.

Victims may gain a sense of mastery over the sexual abuse from testifying. If they are believed, they may derive a degree of vindication when they see that the offender has to pay for what he did. Completing the court process may also engender a sense of closure for the victim.

On the other hand, victims may experience court testimony as additional trauma. Some are required to confront their abusers, endure lengthy cross-examination, and reveal shameful experiences to an audience. If possible, the courtroom should be cleared during the child's appearance. Testifying in court, which rarely entails a single appearance, may enhance the child's perception of him/herself as a victim, rather than a normal child. Moreover, because the court process tends to be protracted, it may delay resolution of the victim's treatment issues. For more detailed information on the role of the court in child abuse and neglect cases, the reader is referred to another manual in this series entitled *Working With the Courts in Child Protection*.

Visitation

As noted previously, in most cases it is appropriate for the offender to leave the home and for the victim to remain. In other cases, the victim should be removed to protect her/him from further sexual abuse and/or emotional abuse. (In a very small number of cases, it will be appropriate to leave the family intact after disclosure.) Obviously what constitutes visitation will vary depending on the living arrangements.

However, there are some guidelines to be used by the court and the professionals in making decisions about visitation. Many professionals recommend no contact between the victim and the offender, if the child is to appear in court, until after her/his testimony. If the mother and/or other family members are unsupportive of her/his testifying, they may be prohibited from seeing her/him until after her/his testimony.

If the child genuinely does not wish visitation, there should be none. There should be no unsupervised visitation until the child feels she/he will be safe and the offender has been assessed and found not at risk to reoffend. In some cases, the child may want visitation or unsupervised visitation when it is not deemed in her/his interest by the professionals. In such a circumstance, professional opinion should prevail.

Assuming all parties want visitation, as the offender (and other family members) make progress in treatment, visitation is initiated and becomes progressively more liberal (i.e., more frequent, for longer time periods, and with less supervision). As successive steps are taken to make visitation more liberal, it is important to make sure the victim (and her/his caretaker) want this change. The multidisciplinary team or the child's therapist needs to make these decisions.

CAUSAL MODELS OF SEXUAL ABUSE

Before developing a treatment plan, it is important to have an understanding of why the sexual abuse occurs, both generally and in the particular case under consideration.

It is useful to briefly examine the history of causal theories of sexual abuse before a discussion of the current level of professional understanding. Historically there have been two rather separate efforts to understand the phenomenon of sexual abuse, its causes, and its resolution. These can be conceptualized as the family-focused perspective and the offender-focused perspective.

The Family-Focused Perspective

Those taking a family perspective focused their attention on incest and developed hypotheses that family dynamics are at the root of sexual abuse. Specifically, clinicians taking this perspective described the collusive mother, who has estranged herself from the father, as the "cornerstone" of the incestuous triad and the victim as a parental child who has replaced her mother as sexual partner to the father.[111]

The implications of this model in terms of treatment are that the mother and the daughter must change, but the offender is not necessarily required to take responsibility for his behavior and develop strategies to control it. Most professionals working in the sexual abuse field recognize the limitations of a perspective that focuses purely on family dynamics.

This perspective does not help very much in explaining extrafamilial sexual victimization and, taken to its extreme, represents the offender as the hapless victim of family dynamics. Moreover, recent research, which finds that a substantial proportion of incest offenders begin their sexual victimization as adolescents and experience arousal to children before they become fathers, calls into question assumptions about the pivotal role of family dynamics in incest.[112]

The Offender-Focused Perspective

Those who work primarily with perpetrators have historically been located in institutions for adjudicated offenders. Most of these clinicians/researchers appreciate that their clientele do not represent the full spectrum of sex offenders. Their focus has been on understanding the etiology of sexual abuse by examining the physiological and psychological functioning of offenders. They typically do not have access to families to understand any role they might have played in the victimization, nor its impact on the families. Moreover, as these clinicians develop and implement treatment strategies, they may have to do so in a vacuum and in an artificial environment. There are frequently both problems translating what is learned in treatment in the institution to the offender's normal environment and failure to continue needed treatment when the offender returns to the community.

An Integrated Model

Efforts to integrate the family and offender perspectives to the causes of sexual abuse began in the mid-1980's. Finkelhor examined the spectrum of clinical literature and research into the causes of sexual abuse and developed a model of causation that incorporates both the family-, and offender-focused perspectives. He posits four preconditions that must obtain for sexual abuse to occur: factors related to the offender's motivation to sexually abuse; factors predisposing the offender to overcoming internal inhibitors; factors predisposing to overcoming external inhibitors (e.g., absence of environmental obstacles); and factors predisposing to overcoming child's resistance (e.g., a vulnerable child or the use of coercion). Finkelhor applied this model on both the individual (case) level and the sociocultural level.[113 114]

The model presented here is somewhat different and more practice-focused. It proposes that there are some causal factors that are *prerequisites* for sexual abuse and there are others that play a *contributing* role. Prerequisite factors—sexual arousal to children and a propensity to act on arousal—are to be found within the offender, whereas contributing factors may come from the culture, from the family system (including the marital relationship), from his current life situation, from his personality, or from his past life experience.

Chart 4. An Integrated Model of the Causal Factors of Sexual Abuse

PREREQUISITE FACTORS	CONTRIBUTING FACTORS	SEX ABUSE*
Sexual arousal to children **and** **Propensity to act on arousal**	**Culture** Culture of male dominance Values re: male sexuality and female roles **Family** Marital discord Sexual dysfunction in marriage Unprotective mother "Seductive" child **Environment** Social isolation Unsupervised access to children Unemployment **Personality** Alcoholism/substance abuse Poor social skills Low self-esteem **Past history** Traumatic sexual experience as a child Sexually abusive role models Nonnurturing childhood	

*Since the vast majority of offenders are male, the model assumes a male offender.

The presence of the two prerequisite factors (sexual arousal to children and propensity to act on arousal) is both necessary and sufficient to result in sexual abuse. This is not the case for the contributing factors. For example, a man does not sexually abuse his daughter because his marriage is unhappy. More than half of American marriages end in divorce, suggesting that a substantial number of marriages are unhappy. But only a very small number of men in unhappy marriages sexually abuse their children.[115 116]

Contributing factors may enhance the prerequisite factors or they may, independent of an effect on the prerequisites, increase risk. An example of the former dynamics is found in the role of alcohol abuse. It usually leads to diminished capacity to control behavior, which may increase the propensity to act on sexual arousal to children. (Chemicals are also used by some offenders to cope with guilt related to their abuse behavior.) An example of the latter dynamic is that found in situations of unsupervised access to children. It may enhance risk because it provides opportunity for an offender who is aroused to children and prone to act on that arousal. This model will be referred to again in the discussion of treatment issues.

TREATMENT MODALITIES

In this section, the role of various treatment modalities is described. An approach to treatment that addresses prerequisite and contributing causes of sexual abuse and meets the treatment needs of victim, family, and offender must be multimodal. Ideally, individual, dyadic, family, and group treatment modalities should be available, especially if reintegration of the offender and/or the victim into the family is planned. However, therapists and programs without this full spectrum of services can be successful in treatment.

Although group, individual, dyadic, and family modalities should be available, it does not appear to be necessary to have a rigid progression from individual to dyadic to family therapy. However, it is crucial that progress be made in individual and sometimes dyadic therapy before family therapy is indicated and before individuals can benefit from it. The types of treatment and their uses will be discussed as follows:

- **Group therapy** is generally regarded as the treatment of choice for sexual abuse. However, usually groups are offered concurrent with other treatment modalities, and some clients may need individual treatment before they are ready for group therapy. Furthermore, there will be a few clients who are either too disturbed or too disruptive to be in group treatment.

  - Groups are appropriate for victims, siblings of victims, mothers of victims, offenders, and adult survivors of sexual abuse. In addition, "generic" groups that include offenders, parents of victims, and survivors of sexual abuse have been found to be very powerful and effective for all parties involved.

  - Groups may be time-limited, long-term, or open-ended. They may deal with specific issues (e.g., relapse prevention, sex education, or protection from future sexual abuse), or they may deal with a range of issues. Some programs have "orientation" groups for new clients, usually with separate groups for children and adults.

  - Victim's and offender's groups have been brought together for occasional sessions. Models that have concurrent groups for victims or children and their nonoffending parents, where from time to time the two groups join for activities, are very productive.

- **Individual treatment** is appropriate for victim, offender, and mother of victim (as well as for siblings of victims and survivors). As a rule, an initial function and a major one for individual treatment is alliance building. All parties have to learn to trust the therapist and come to believe that change is possible and desirable. The members of this triad may have different levels of commitment to therapy, with the victim usually the most invested and the offender the least.

- **Dyadic treatment** is used to enhance and/or repair damage to the mother-daughter relationship, the husband-wife relationship, and the father-daughter relationship, as well as to deal with issues initially addressed in individual treatment.

- **Family therapy** is the culmination of the treatment process and is usually not undertaken until there has been a determination that reunification is in the victim's best interest.

- **Multiple therapists** can be very helpful. Such a complex series of interventions can rarely be provided by one individual. If possible, two therapists should be involved, even if it is only one person doing the group work and another the individual, dyadic, and family work. However, because each

family member will typically participate in a group as well as other treatment modalities, there are usually several clinicians involved with a single family. Moreover, there are reasons other than logistics for involving several clinicians.

- Sexually abusive families are very difficult to work with, and therapists need one another's support. Such families are crisis-ridden and multiproblem, making it very difficult for one person to have total responsibility for the family.

- Assigning a different therapist to the victim and to the offender "recreates," although artificially, a family boundary that was crossed when the sexual abuse occurred. It also enhances a sense of privacy and safety for the victim—two elements violated by the offender.

- In addition, cotherapy, using both a male and female therapist, has considerable therapeutic advantage. It exposes family members to appropriate role models of both sexes. Cotherapy also enhances the ability of clinicians to effect change because of the leverage it allows, particularly in group therapy.

- Finally, decisions that must be made in the course of treatment are very difficult ones, and mistakes are potentially devastating. Two or more heads may be better than one. And as noted earlier, ideally clinicians should be guided in their decisions by the input of a multidisciplinary team.

TREATMENT ISSUES

There are two main objectives in sexual abuse treatment:

- dealing with the effects of sexual abuse, and
- decreasing risk for future sexual abuse.

Victim treatment tends to focus more on the former; mother's treatment issues are fairly evenly split; and the offender's issues are predominantly in the realm of preventing future victimizing behavior, although the initial stage of treatment may focus on the effects of the abuse disclosure on him/her.

Treatment Issues for the Victim

The saliency of treatment issues discussed in this section will vary for each victim, some possibly being irrelevant. Also, there may be additional treatment issues for victims that are not discussed here. The following issues appear to be the most important:

- trust, including patterns in relationships;
- emotional reactions to sexual abuse;
- behavioral reactions to sexual abuse;
- cognitive reactions to sexual abuse; and
- protection from future victimization.

These issues are interrelated. As the following discussion illustrates, the categorization is somewhat artificial.

Trust

Being a victim of sexual abuse can have a devastating effect on children's object relations, particularly the ability to trust other people. In intrafamilial sexual abuse, the impact may be pervasive because a caretaker, who should be a protector and a limit-setter, exploits the child and violates the boundaries of acceptable behavior. Furthermore, this damage may be exacerbated by an unsupportive nonoffending parent. Moreover, sexual abuse may not be the only way in which the child's trust is undermined. The victim may experience other maltreatment or traumatic experiences in the family.

However, children sexually molested outside the home may also experience problems with trust. This may come about because the person who victimizes the child is someone to whom the child has been entrusted by the parents, as happens, for example, when the abuser is a child care provider. These victims frequently perceive their parents as having given permission for the exploitation. Alternatively, the offender may be a person in a position of authority over the child and she/he feels compelled to comply. Then children may have considerable difficulty trusting persons in positions of authority in the future.

The challenge to the therapist is to create circumstances in which the child has positive experiences with trustworthy adults in order to ameliorate the damage to the child's ability to trust. This may involve rehabilitating the parents and/or creating opportunities for appropriate relationships with adults, for example, with foster parents, mentors, or other relatives. An admonition to therapists is that they must be honest and dependable in order to create an atmosphere of trust.

Emotional Reactions to Sexual Abuse

Three common emotional consequences of sexual victimization are a sense of somehow being *responsible* and therefore feeling *guilty*, an *altered sense of self and self-esteem* because of involvement in sexual abuse, and *fears and anxiety*.

- **Feeling responsible**. An offender may make the victim feel responsible for the sexual abuse, for the offender's well-being, and/or for the consequences of disclosure. Victims may also feel guilty for not having stopped the sexual abuse as well as for any positive aspects of the abuse, such as physical pleasure, the special attention given by the offender, or an opportunity to have control over other family members because of "the secret."

The role of the clinician is to help the child understand intellectually and accept emotionally that the child was not responsible. The adult sexually abused the child; the child did not sexually abuse the adult. It was the adult's job—not the child's—to stop or prevent the abuse.

- **Altered sense of self**. Guilt feelings as well as the invasive and intrusive nature of the sexual activity impact negatively on the child's sense of self and self-esteem. As Sgroi puts it, victims suffer from "damaged goods" syndrome.[117] The effect is both physical, in that children have an altered sense of their bodies, and psychological, in that children may see themselves as markedly different from their peers.

The task of the therapist is to make victims feel whole and good about themselves again. Work, mentioned above, that addresses the issue of self-blame is helpful. However, so are interventions that help children view themselves as more than merely victims of sexual abuse. Normalizing and ego-enhancing activities, such as

doing well in school, participating in sports, getting involved in scouts, or helping a younger victim, can be very important in victim recovery.

- **Anxiety and fear** to be discussed here are related to the traumatic impact of the abuse *per se* on the child rather than environmental responses to it. The victim develops phobic reactions to the event, the offender, and to other aspects of the abuse. Experiences that evoke recollections of the abuse come to elicit anxiety. In some children this anxiety and phobias become pervasive and crippling because of the level of avoidance they engage in to reduce their stress.

Before treating the child's fears and anxiety, the therapist must be sure the child is not being sexually abused or at risk for sexual abuse. Then the therapist engages the victim in a series of interventions that allow her/him to gradually deal with the abuse and related phobias and anxiety in ways that usually avoid excessive stress and allow mastery.[118] These may include discussions, play therapy, or interventions in the child's environment. For example, the victim may be encouraged to ventilate by talking about the abuse and accompanying feelings, thereby reducing the level of distress related to it. Similarly, a child who is phobic about being left with a babysitter may be left with a relative first for short and longer time periods, then with a babysitter for brief and then longer periods and thereby be desensitized to babysitting situations.

- **Additional emotional reactions** may be found. Depending on the circumstances of the victimization and the child's personality, she/he may react with *regression, anger, depression, revulsion*, or *posttraumatic stress disorder* to sexual abuse. These emotional reactions are likely to manifest themselves in problematic behaviors. These behaviors will be discussed in the next section.

Behavioral Reactions to Sexual Abuse

As suggested in the second chapter, behavioral effects of sexual abuse can include sexualized behavior and other behavior problems.

- **Sexualized behavior**. A serious reaction is sexualized behavior. Children who have been sexually victimized may masturbate excessively and openly or sexually interact with other people. Every act of sexualized behavior has the potential for increasing the probability of future acts. Not only is the activity likely to be physically pleasurable, but it may also enhance the child's view of her/himself as a sexually acting out person. Such acts may also stigmatize the child, which has a negative impact on the child's sense of self.

Clinicians should work to diminish and/or eliminate sexualized behavior through teaching behavioral controls. Sexual acting out may be controlled, for example, by teaching the child to masturbate privately. Behavior management techniques, which can involve rewarding "sex-free" days and using "time-out" for sexual acting out, can be taught to the child's caretaker. In addition, the child's energies that might have gone into sexual behavior can be channeled into more age-appropriate activities by having a caretaker monitor the child, interrupt any sexual acting out, and provide opportunities for positive alternative behaviors. These interventions are conducted with the child's caretaker and/or in dyadic work with child and caretaker.

One of the reasons treatment of sexualized behavior is so essential is because of a recently recognized phenomenon called the *victim to offender cycle*. Both male and female victims are at risk for this problem. Many offenders begin as victims, whose response to sexual abuse is to identify with the aggressor and to sexually act out in order to cope with their own sense of vulnerability and trauma. Professionals must recognize the potential danger of allowing sexualized behavior to go untreated, which is that the child then

is at risk for becoming first an adolescent offender and eventually an adult offender. The child not only damages him/herself, but also may cause grave harm to many other children over the course of time.

- **Other behavior problems**. Other behavioral reactions to sexual abuse include such problems as *aggression* toward people and animals, *running away*, *self-harm* (cutting or burning), *criminal activity*, *substance abuse*, *suicidal behavior*, *hyperactivity*, *sleep problems*, *eating problems*, and *toileting problems*.

Some of these problems, for example, difficulties with sleep, eating, toileting, and being alone, may be acute after disclosure but diminish over time and eventually disappear. Short-term intervention, labeling the behavioral problems as common reactions, and helping the victim resolve the underlying emotional or cognitive issues is generally helpful. Parents are encouraged to be understanding.

Treatment strategies for all behavioral problems include helping the victim understand the relationship between the behaviors and the sexual abuse and emotional or cognitive reactions to it; helping the child develop insight into the self-destructive nature of some of these behaviors; assisting the victim in more appropriate expression of the emotions, for example, anger; and behavioral interventions to diminish and eliminate problematic behavior. With older children, group therapy is usually very useful in addressing these problems.

Cognitive Reactions to Sexual Abuse

An important part of treatment of victims of sexual abuse is to help them understand the meaning of the abuse. This includes learning what appropriate and inappropriate touching entails; what is wrong about sexual activity between adults and children, if they do not know this; why adults or a particular adult was sexual with them; and in some cases, why they were chosen as targets and what that means to them. How these issues are addressed will vary with the child's developmental stage. They may be more adequately dealt with in group treatment than individual therapy, and sometimes having the offender take full responsibility for the abuse in dyadic therapy with the victim is useful.

Moreover, an adequate explanation for a child at a young age may not be sufficient as she/he grows older. Thus, this particular issue will need to be addressed at a more sophisticated level as the child matures. This may be done by a parent but in some cases will need to be done by a therapist.

Protection From Future Victimization

Treatment of victimized children needs to include strategies for future protection. Teaching children to say no and tell someone may be useful, especially if the material is presented in a group setting and there are opportunities to role play resisting sexual advances. Specific protective strategies involving family members and helping professionals need to be developed in intrafamilial sexual abuse situations. Additionally, the therapist must appreciate that placing even partial responsibility for self-protection on the victim is potentially an overwhelming burden.

Treatment Issues for the Mother (Nonoffending Parent)

Although the discussion that follows refers specifically to mothers as nonoffending parents, much of the material is also applicable to nonoffending fathers. Treatment issues for mothers of victims can be categorized under the following four general headings.

- issues related to the sexual abuse,
- issues related to the mother-victim relationship,
- issues related to the offender (spouse), and
- other personal issues.

These issues are particularly relevant to cases involving mothers in intrafamilial sexual abuse but also can be important when other persons are the abusers. Like victim treatment issues, they are interrelated, and there may be other issues that are salient in a given case. The relationship of the mother's treatment issues to factors to be assessed in making decisions about victim reunification with the family will become apparent.

Issues Related to the Sexual Abuse

It is difficult for most people, including mothers of victims, to *understand why an adult might want to be sexual with a child*. This is often the first issue that the clinician must address with the mother. This may be especially difficult for the mother to understand if the offender is her spouse or another close relative.

The therapist may offer professional understanding into the general causes of sexual abuse or those specific to the case. The parent might also be given material to read. However, group involvement, in either a generic sexual abuse or mothers' group, may be the most effective method for addressing this issue.

A related issue is that of *believing the victim's disclosure* of sexual abuse. Many parents will try to explain it away. As noted in the discussion of assessment of the nonoffending parent, coming to believe a victim is usually a process, rather than instantaneous.

The therapist may describe what in the child's disclosure makes her/him believe the child or speak generally about the conclusion that children rarely make false allegations and the reasons for that belief. However, group treatment, in which the mother is confronted by others who have also struggled with disbelief, is often the most effective mode for dealing with this issue.

Finally, the therapist will want to help the mother *understand her role in the abuse*, if she has had one. The nonoffending parent is not to blame for the victimization but in some instances may have contributed to risk of abuse or prolonged abuse, for example, by leaving the child for long periods of time with the offender or by discounting the child's early disclosures.

Interestingly, a good prognosis is suggested when a mother feels very guilty and the therapist must work to alleviate her sense of responsibility. Conversely, a poorer prognosis is indicated when the mother sees herself as absolutely blameless and the therapist has to point out things that the mother might have done differently that could have prevented or minimized the abuse. As with other issues related to the abuse, this issue may be best dealt with in group therapy.

Issues Related to the Mother-Victim Relationship

Treatment of intrafamilial sexual abuse that results in successful reunification of the family rests upon the *mother's relationship with the victim*. This may be a very problematic relationship at the time of disclosure. The offender may have engaged in manipulations that have alienated mother and victim from one another. The victim may have developed problematic behaviors because of the abuse, which have damaged her relationship with the mother. The consequences of disclosure may be blamed on the victim, or the mother may never have related well to the victim (or other people).

This problem appears to be less severe with boy victims. Mothers are more likely to be supportive of them. In part this is because when boys are sexually abused, the offender is more often, than with girls, someone outside the family. Moreover, when victimized within the family, boys tend to be abused along with their sisters,[119] meaning the mother is less likely to regard a single child as to blame or as the source of her frustrations. However, this phenomenon may also relate to differences in role relationships between mothers and daughters and mothers and sons.

The therapist tries to enhance the mother-victim relationship by assisting the mother in developing empathy for the victim; by facilitating their communication; by helping them resolve ongoing problems in their relationship, such as disputes regarding bedtime or chores; and by helping them develop opportunities for mutually enjoyable experiences. Initial work is usually done in individual treatment with the mother, and later within the mother-child dyad.

Improving the mother-child relationship is generally a prerequisite to assisting the mother in being *protective of her child* in the future. Although interventions are employed to help the offender control his behavior in the future, the major source of protection for the child is the mother.

Intervention to make the mother more protective is implemented in a variety of ways. If the mother has a more positive relationship with the child, she will be more predisposed to protect the child. Treatment to improve the mother-child communication should enhance the likelihood the child will tell mother. Moreover, the therapist usually works with both the child and the mother to encourage communication specifically about the child's safety.

Especially if the family has not been separated or, if separated, as the family is reunited, specific guidance should be given to the mother regarding safety. For example, she may be instructed not to leave the child alone with the offender, not to let the offender bathe the child, not to allow the offender any control over the child's activities, and/or not to give the offender the responsibility for disciplining the child. How long these protections remain in place will depend on the case.

Finally, the therapist usually helps the mother develop a specific plan in case the offender does reoffend. Her plan is communicated to the victim, the offender, and the rest of the family. It can often involve dissolving the marriage.

Issues Related to the Offender (Spouse)

In cases of intrafamilial sexual abuse, the mother must decide whether she wants to *sever her relationship with the offender or try to salvage the relationship*. Some mothers decide at the time of disclosure to terminate the relationship or, alternatively, to work to preserve it. For others, this decision takes time and observation of the offender's progress or lack thereof in treatment. Still others are indecisive and change their minds more than once.

The clinician may have an opinion about what the mother should do. However, it is wise to allow the mother to make her own decision. This does not preclude sharing opinions about the offender's treatability and the likelihood of the victim remaining or returning home should the mother choose to stay with an untreated or untreatable offender.

In cases in which the offender is the mother's partner, regardless of the decision to leave or to stay, the mother will need to address her *relationships with men*. The goal is to help her gain some insight into these relationships, including that with the offender, and to understand their problematic aspects. If she intends to stay with the offender, she must be assisted in changing that relationship. If she leaves him, the goal of insight is to help her

in future relationships. Group treatment with other mothers is particularly useful in this work. Of course, if her intention is to preserve the relationship with the offender, dyadic work with the offender is necessary.

Often mothers are very dependent on the men who have abused their children. In most instances, it is important to help her *become less dependent* so that she will be better able to seek what is in her children's and her interest, should there be a conflict between the offender's interest and that of the rest of the family.

Independence may be fostered by involving the mother in activities outside the home, including therapy; enhancing her financial independence; encouraging her to do things without his assistance; and facilitating her assertiveness when they are in conflict. Opportunities for these types of interventions may present themselves quite naturally if the offender must leave the home at the time of disclosure of the sexual abuse. Because of the mother's need to function autonomously in his absence, he may return home to a situation quite different from the one he left.

Other Personal Issues

Most mothers must deal with other issues related to current functioning and past experiences in therapy. The most common issue regarding current functioning is *low self-esteem*. However, other issues, such as *substance abuse*, *experiences of violence*, *dependency*, and *emotional problems*, often need to be addressed as well.

The most common issue in terms of past trauma is *having been sexually victimized themselves*. Such an experience can have a variety of implications in terms of the mother's ability to deal with her children's sexual abuse. For example, at the time of disclosure, a mother may be so overwhelmed because of her own abuse that she cannot deal with her child's victimization. In such instances, her abuse may have to be addressed first. Her own victimization may have an impact on her willingness to believe the victim, her ability to discern risky situations (she may not note them), and her choices of partners, playing a role in her choosing someone who is sexual with children. In addition, it may cause her to mistakenly believe her children are being victimized.

Treatment Issues for the Father as the Offender

Although the following discussion will refer to the father as the offender, it is equally applicable to cases involving stepfathers and unmarried partners of mothers who are offenders. It is also relevant to some situations involving other intrafamilial offenders. Treatment issues for the offending fathers can be broadly defined as falling into three categories:

- issues related to the father's past sexual victimization of children,
- issues related to the father's possible future victimization of children, and
- other dysfunctional behaviors and problems.

These broad categories tend to be overlapping.

Issues Related to the Father's Past Sexual Abuse of Children

In many cases, the first challenge for the clinician is obtaining a confession of the sexual offenses. Many fathers are too ashamed to admit what they have done. Others are reluctant to disclose their abuse during litigation because they are afraid of its impact on the outcome. They may be more willing once the court case is resolved. Others are ordered into treatment by the court while continuing to protest their innocence.

Operationally, confession means an admission to all of the acts the child has described. However, it is common for the child not to disclose all of the abuse; therefore, it is important for the offender's therapist to stay in touch with the victim's therapist in case there are additional disclosures. (In treating intrafamilial sexual abuse, it is important for each family member to consent to share information with each therapist treating each family member.) To obtain a confession, the therapist actively confronts the father with the information on his offenses provided by the victim and others. In addition, group treatment, in which the father observes others confessing their victimizing behavior, can facilitate full disclosure.

With confession must come an *acceptance of responsibility* for the abusive acts. That is, the father must disavow any past excuses, such as his wife was not giving him sex or that he was drunk at the time. He must not minimize the behavior by saying, for example, "it only happened once," "there was no penetration involved," or "I stopped when she asked me to." As is probably apparent, it is extremely difficult to know when the offender has actually accepted responsibility rather than saying what he thinks the therapist wants to hear. Again, the use of group treatment can be especially helpful because other offenders may be more capable of discerning and confronting deception than a therapist.

A related task of treatment is for the father to *appreciate the harm the abuse has caused the victim, his partner, and finally himself.* There may be others affected as well, for example, siblings of the victim and the extended family. Some sort of communication from the victim and the offender's partner about the effects of the abuse on them can be useful. This may be in the form of a letter, a video or audiotape, or a face-to-face confrontation involving the therapist. Generic groups in which offenders are confronted by adult survivors and mothers of victims, other than the offender's own, can facilitate these insights. Written accounts, by victims, journalists, and professionals, of the impact on victims may be used, and offenders' groups can be the context for this work. As with the issue of responsibility, being sure the father is doing more than saying the right thing is a significant challenge.

At some point in treatment after the offender has confessed, taken responsibility, and come to appreciate the harm he has done, a *series of apologies* should be made. The offender must apologize to the victim, to his partner, and to the family in intrafamilial cases. There may be others who have been affected and deserve an apology as well. This is a process, not a single act, usually conducted in the context of dyadic or family treatment. The fact that the offender apologizes does not imply that the victim and others need to forgive him. These interventions need to be carefully orchestrated and controlled by the therapist. Only after the offender has completed the process, demonstrating an appreciation of the harm done, should his return home be considered.

A final treatment issue related to past abuse has to do with prevention. In order to prevent future sexual abuse, it is important for the offender and the therapist to understand *why the offender sexually abuses children.* In this regard, the model presented earlier in this chapter is relevant.

Thus, the treatment process involves coming to understand the offender's *arousal pattern and why he acts on the arousal.* Then *contributing factors* are explored.

Sexual arousal to children. Arousal patterns vary. They may be conceptualized as follows:

- **Child is the offender's primary sexual object**. Some offenders' sexual preference, sometimes exclusively, is for children. The term *pedophile* is generally used to refer to this type of offender. Often pedophiles not only prefer children, but children of a particular age and sex. Pedophiles tend to have multiple victims and actively seek opportunities whereby they can have sexual access to children, by choosing vocations and avocations that afford them contact with children. A contributing factor to this type of arousal pattern is often traumatic childhood sexual experience.[120]

- **Child is one of multiple sexual objects**. Other offenders have multiple *paraphilias* or aberrant sexual preferences and sometimes normal sexual preferences as well. The behavior of these offenders is characterized by sexual contact with children but may also include rape of adults, promiscuity with adults, exposure, voyeurism, sadomasochism, group sex, bestiality, and other sexual acts. The term *sexual addict* is often applied to this type of offender. The contributing factors or etiology of this pattern of sexuality appear to be a combination of childhood and adolescent experiences.

- **Child is a situational sexual object**. Finally, there are offenders whose normal sexual orientation is toward peers but who become aroused by children under certain circumstances. Factors that contribute to such arousal may include the absence of other sexual outlets, stresses affecting normal marital and/or peer relations and communications, child pornography, and physical exposure or contact to children that is sexually stimulating. Although initial sexual contact involving this type of offender may be situationally induced, the experience may be very gratifying. Clinical experience indicates this is likely to result in an increased desire for and preference for sex with children.

As may be apparent from the last point, although these three arousal patterns are presented as though they are discrete, they probably are not. For example, it may be inappropriate to classify some offenders as having either a primary orientation to children or to adults.

Understanding the offender's arousal patterns may be done by having the offender describe what he experiences about his victims as arousing, having him discuss in detail his sexually abusive behavior, having him reveal his sexual fantasies, or measuring his erectile responses to various visual and auditory sexual stimuli using the penile plethysmograph.* Treatment prognosis with pedophiles and sexual addicts is much poorer than for those who have situational sexual arousal to children.

The propensity to act on arousal. There is research that suggests that a substantial minority of the male population experiences sexual arousal to children.[121] (Comparable research has not been conducted on women.) However, it appears that a great many more men experience these feelings than act on them. The willingness to act on these feelings appears to be related to one or in most cases more than one of the following deficits:

- pervasive superego deficits,
- circumscribed superego deficits,
- cognitive distortions,
- impulse control difficulties, and
- diminished capacity.

Persons whose *superego deficits* are *pervasive* have little or no conscience. The term *psychopath* is often applied to them. This condition is thought to be a result of early traumatic life experiences. Those who have *some superego deficits* may experience an absence of conscience related specifically to sexual activity or sexual activity with children, or they may generally have a weak or impaired superego. Some combination of early experience, lifestyle, and cultural norms may create this sort of superego. Differing in degree is the offender who has *cognitive distortions* related to his sexual deviance. He will have persuaded himself that

---

* The plethysmograph consists of a gauge attached to the offender's penis that can measure and systematically record tumescence.

sexual abuse is not bad or not so bad by such rationalizations as "The child won't know what I'm doing so it's not harmful" or "Everyone needs sex; this is my way." After the initial act, distortions may be "The child didn't resist, so she must have liked it," "There was no penetration so it wasn't really sexual abuse," or "It's my wife's fault because she withheld sex from me." Some offenders appreciate that what they do is wrong, but they do it anyway because they have *poor impulse control*.

Finally, some offenders experience *diminished capacity*, which enhances propensity to act on arousal. Typically, this is a temporary condition, and its most common cause is substance abuse. Thus, the offender acts on his arousal because alcohol or drugs have decreased his ability to control his behavior. Initial instances of victimization when drunk may occur without a prior plan. However, subsequently, the offender may drink so that he will have an excuse to abuse. Furthermore, after the initial acts, the attraction of the behavior itself may increase and chemicals are less necessary to diminish control. There can be other causes of diminished capacity. Offenders may lack adequate ability in handling stress, depression, anxiety, and/or anger in healthy ways. In addition, some persons suffer from chronic diminished capacity as a result of mental retardation or organic brain syndrome. If they experience arousal to children, it will make them at ongoing risk for sexual abuse.

Contributing factors. Some factors that may enhance arousal or increase the propensity to abuse have been described above. There may be others factors that act on these prerequisites and ones that independently contribute to risk for sexual abuse, for example, child behaviors, mother behaviors, and opportunity to sexually abuse.

It is an important part of the treatment process to understand why the offender has sexually abused children so that he can be empowered to gain control over his arousal and propensity to act on arousal. Some of the intervention that addresses contributing factors may be initiated with the offender alone, but much is done in the treatment of other individuals in the family and in dyadic and family work.

Issues Related to Possible Future Sexual Abuse

As noted in the previous section, preventing future sexual abuse relies on understanding what made the offender abuse in the first place. In this section, interventions that address arousal to children and propensity to act on arousal are discussed.

Sexual arousal to children. It has already been pointed out that sexual and other trauma during childhood may play a role in later sexual arousal to children. However, understanding the relationship of the offender's previous history to his arousal patterns is probably the least useful in prevention of future sexual abuse. In fact, often offenders manipulate the treatment process so that past history becomes an excuse for their offending. In spite of this risk, for some offenders, understanding the origins of previously incomprehensible behavior can render it manageable. Moreover, realizing that what the offender learned about sex roles as a child was wrong can lead to the development of more appropriate definitions of sex role behavior.

When deviant arousal patterns have been defined, the therapist will attempt to change these patterns. That is, the therapist will endeavor to decrease sexual arousal to children and increase arousal to appropriate sex objects. This is done through a variety of behavioral interventions that rely on both respondent and operant conditioning. These techniques include aversive conditioning, covert sensitization, thought stopping, masturbatory satiation, behavioral rehearsal, systematic desensitization, and masturbatory reconditioning. These techniques are often used in conjunction with social skills training, empathy training, and behavioral assignments.[122]

Behavioral interventions are exacting, and some require a laboratory setting. They also require the full cooperation of the client if they are to be successful. Moreover, the changes they create are not assumed to be permanent (nor are those from other types of intervention), and clients may need booster sessions. Many mental health professionals are untrained in and uncomfortable with behavioral interventions. However, to date they are the only therapeutic techniques that have been found, based on empirical evidence, to decrease sexual arousal.[123] It behooves every clinician treating offenders to be familiar with these techniques and use those that can be suitably employed in his/her agency.

The propensity to act on arousal. Two approaches may be used to address propensity to act: techniques that enhance superego functioning by *taking responsibility* for sexual abuse and *relapse prevention*. Offenders whose propensity to act is based on pervasive superego deficits will probably not respond to treatment to reduce this propensity. However, those who have circumscribed superego deficits or are engaged in cognitive distortions probably will respond to interventions to address superego deficits. Treatment that is focused on getting the offender to take responsibility for his abusive behavior, to appreciate its harm, to acknowledge the feelings of traumatized parties, and to make amends or reparation is meant to enhance the offender's superego functioning and eliminate cognitive distortions, thus decreasing the probability of his acting on arousal in the future. Making amends or reparation usually involves a physical (e.g., community service) or monetary consequence that may serve to teach empathy and inhibit further abuse. In addition, when an offender lacks a strong internalized superego, the fact that there will be consequences for reoffense, such as prison or his wife leaving him, serves as an external superego. The strength of such interventions is in their deterrent effect.

In recent years, sex offender therapists have experienced success by using relapse prevention strategies, a technique borrowed from addiction treatment, in their intervention.[124] Relapse prevention addresses propensity to act based on impulse control problems, reduced inhibition, and diminished capacity. Relapse prevention assumes that there are emotional states and behaviors on the offender's part that precede and ultimately precipitate the sexually abusive behavior. Often the offender is unaware of these factors and believes that his behavior is out of his control.

The clinician assists the offender in understanding these precursors and helps him develop a plan to manage such situations so that he does not reoffend. The clinician uses disclosures from the offender and others, including the victim, to obtain an accurate understanding of the circumstances that led to offending. Obviously such an intervention requires a candid and cooperative offender.

With some offenders, particularly those with cognitive limitations and difficulty being introspective, the clinician merely teaches the offender to anticipate, identify, and avoid risky situations. Thus, the offender may be instructed that he cannot assist at summer camp anymore or he cannot be left alone with his daughter.

With other offenders, the clinician helps him understand the chain of events, often seemingly unrelated to the sexual abuse, that precedes the victimization. This might include a series of procedures, such as the grooming process an offender may employ in the seduction of his victim, or acts such as getting upset with his wife and getting drunk after she goes to bed as a prelude to going into the daughter's room to molest her. The therapist then teaches the offender to interrupt the chain of events rather early while he still has control of his behavior. Thus, the pedophile is instructed to avoid driving by playgrounds, and the offender whose abuse is precipitated by drunkenness is instructed to abstain completely. If he has a serious substance abuse problem, he is sent to a substance abuse treatment program, either before treatment of his sexually abusive behavior is begun or in conjunction with sexual abuse treatment.

The relapse prevention plan is usually written out, and the offender carries it with him so he can refer to it when he thinks he is in a high-risk situation.

Interventions with the family mentioned earlier, such as not allowing the offender to be alone with the child or to discipline her, are meant to prevent him from being in high-risk situations. Moreover, there are numerous other ways the family and others can be involved in helping the offender prevent a relapse. Because most offenders experience more than one deficit leading to propensity to act, interventions that focus both on his taking responsibility and on relapse prevention are advised.

Other dysfunctional behaviors and problems. The offender may experience many other problems, and often these are contributing factors to the sexual abuse. Examples might be violent behavior, problems with the law, poor parenting skills, marital discord, poor social skills, low self-esteem, lack of education, and unemployment.

These are appropriate foci of treatment, and indeed it may be necessary to treat them because they increase the risk for future sexual abuse. Nevertheless, it is crucial that the clinician not allow him/herself to become sidetracked into only dealing with these other problems. Distraction can occur more easily than one might think if the offender refuses to admit to the sexual abuse or is reluctant to focus on it in treatment, yet is more than willing to work on his other problems. This pitfall is usually avoided if group therapy, which forces the offender to deal with his abuse, is a major component of the intervention and/or if there are several therapists involved in the case.

CONCLUSION

Impressive progress has been achieved in the child sexual abuse field in the last 10 years. Advances have been made in identification, investigation, intervention, and treatment. Sexual abuse cases, perhaps even more than other types of maltreatment, require multidisciplinary, multiagency collaboration in order for professionals to effectively act in the victim's and family's best interest. Many communities have developed guidelines and protocols for handling these cases.

Yet there is still much work to be done. More progress has been made in the identification and investigation of sexual abuse than in treatment, and resources tend to go into these efforts rather than into preventing and ameliorating the problem. There is a startling paucity of treatment outcome studies. Consequently case management decisions and decisions about what techniques to use in treatment are made by clinicians without empirically tested guidelines.

Moreover, despite the progress in identification, many cases still go undetected. Further, our investigative techniques do not guarantee all victimized children will disclose, and many cases are still inadequately investigated. Moreover, in too many instances children's disclosures are met with skepticism, and the conscientious work of professionals acting on their behalf is challenged.

Although in part professional shortcomings relate to the fact that our abilities to address sexual abuse are still developing, they are largely the result of lack of adequate resources. Caseloads for child protection staff and foster care workers are too large; their training is inadequate; and because of the stresses of the job, their turnover rates are unacceptably high. There are too few trained clinicians who can provide treatment to families and individuals involved in sexual abuse, and when skilled professionals are available, there are often insufficient funds to pay for the necessary treatment. Finally, the funding for research to help us better understand sexual abuse and how to address it is in very short supply.

Nevertheless, professionals in the field of child sexual abuse continue to strive to educate the public and other professionals about this problem and its pervasive effects. Despite the shortage of resources, there is leadership at the Federal and State levels that has played a fundamental role in the substantial progress that has been made. The willingness of adults with prominent roles in the community to identify themselves as former victims and survivors of sexual abuse has added immeasurably to the credibility of child victims and has inspired professionals to continue their work.

GLOSSARY OF TERMS

Analingus - licking, kissing, sucking the anal opening.

Backlash - literally a quick, sharp, recoil; but used figuratively to characterize an opposing reaction to a previous trend; the term used for the current high degree of skepticism found in some circles regarding the truth of allegations of sexual abuse.

Child Sexual Abuse Accommodation Syndrome - behavioral and emotional manifestations of victims' coping with sexual abuse (these include secrecy; helplessness; entrapment and accommodation; delayed, unconvincing disclosure; and retraction); first described by Roland Summit, M.D.

Cognitive Distortions - thinking errors; term used to describe how some offenders rationalize their sexually abusive behavior.

Colposcope - an instrument originally designed for examining the cervix and vagina, using a magnifying lens from 5X to 30X; now being used to examine the external genitalia and document evidence of sexual abuse, often having photographic capability.

Countertransference - the conscious or unconscious reaction of the professional to the client. These reactions can interfere with the process of treatment or other intervention.

Cunnilingus - licking, kissing, biting, or sucking the vagina; inserting tongue into the vaginal opening.

Damaged Goods Syndrome - the negative sense of self and perception of their bodies experienced by victims of sexual abuse; term first used by Suzanne Sgroi, M.D.

Encopresis - inability to control bowel movements.

Enuresis - inability to control urination, especially during sleep.

Erythema - redness and swelling of tissues.

Fellatio - kissing, licking, biting, sucking the penis.

Forchette - refers to the posterior forchette of the female genitalia, where the labia majora join.

Friability - fragility, of the hymen, resulting in a small fissure or fissures, usually at the posterior forchette.

Frottage - rubbing the genitals against a person's body or clothing.

Funneling - anal opening has a hollow channel and is deep-set; this is a consequence of repeated anal penetration and is found in older children (and adults).

Hysteria - a psychological disturbance, arising from trauma, that manifests itself in physical impairment, such as paralysis, blindness, deafness, or anesthesia.

Iatrogensis - illness or pathology caused by the treatment or other intervention intended to ameliorate a preceding problem.

Labial Adhesion - a fibrous band of tissue holding together the labia minora; these occur as a consequence of irritation.

Otoscope - an instrument originally used to examine the ear, using magnification; now also being used in genital exams for sexual abuse.

Paraphilia - aberrant or deviant sexual preference.

Pedophile - an adult whose primary sexual interest is in children; some professionals make a differentiation between a pedophile, whose sexual partner of choice is a prepubertal child, and a hebephile, who is aroused by adolescents.

Perianal Venous Engorgement - a congestion of the blood vessels around the anus.

Petechiae - pinpoint bruises, caused by sucking or pressure.

Plethysmograph or Penile Plethysmograph - a gauge that is attached to the penis and systematically records erectile response.

Psychopath - an individual with no superego or conscience; because of this deficit, the person often engages in extensive antisocial behavior.

Reflex Anal Dilatation - opening of the anus after stimulation.

Sexual Addict - an individual, with particular or multiple sexual preferences, who is preoccupied with these desires and satisfying them, to the point that addressing them becomes consuming.

Sexually Abused Child Disorder - behavioral and emotional indicators of sexual abuse; these vary depending upon the child's developmental stage and vary in their level of certainty as indicators of sexual abuse; described by David Corwin, M.D.

Synechiae - an adhesion or joining together of parts of the body.

Vulvovaginitis - inflammation of the vulva and vagina.

NOTES

1. H. Lerman, "The Psychoanalytic Legacy: From Whence We Come," in L.A. Walker, ed., *Handbook on Child Sexual Abuse* (New York: Springer, 1988), 37–54.

2. G. Masson, *Assault on the Truth* (New York: Farrar, Straus, Giroux, 1984).

3. A.A. Brill, ed., *The Basic Writings of Sigmund Freud* (New York: Modern Library, 1983).

4. L. Bender and A. Blau, "The Reaction of Children to Sexual Relations With Adults," *American Journal of Orthopsychiatry* 22(1952):825–837.

5. A. Yorukgolu and J. Kemph, "Children Not Severely Damaged by Incest with a Parent," *Journal of the American Academy of Child Psychiatry* 5(1966):111–124.

6. K.C. Faller, "Is the Child Victim of Sexual Abuse Telling the Truth?" *Child Abuse and Neglect* 8(1984):473–81.

7. D. Jones and M. McQuiston, *Interviewing the Sexually Abused Child* (Denver: Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1986).

8. D. Jones and E.M. McGraw, "Reliable and Fictitious Accounts of Sexual Abuse to Children," *Journal of Interpersonal Violence* 2(1987):27–45.

9. K.C. Faller, "Characteristics of a Clinical Sample of Victims of Sexual Abuse: Do Boy and Girl Victims Differ?" *Child Abuse and Neglect* 13(1989).

10. D. Finkelhor, *Sexually Victimized Children* (New York: The Free Press, 1979).

11. G. Wyatt, "The Sexual Abuse of Afro-American and White American Women in Childhood," *Child Abuse and Neglect* 9(1985):507–519.

12. D.E.H. Russell, "The Incidence and Prevalence of Intrafamilial and Extrafamilial Sexual Abuse and Female Children," *Child Abuse and Neglect* 7(1983):133–46.

13. Finkelhor, *Sexually Victimized Children*.

14. D. Lykken, "The Detection of Deception," in L. Wrightsman, C. Willis, and S. Kassin, eds., *On the Witness Stand* (Newbury Park, CA: Sage, 1987).

15. Reauthorized by Public Law, 102–295 (1992).

16. Finkelhor, *Sexually Victimized Children*.

17. L. Risin and M. Koss, "The Sexual Abuse of Boys," *Journal of Interpersonal Violence* 2 (1987):309–23.

18. A. Burgess, *Child Pornography and Sex Rings* (Lexington, MA: Lexington Books, 1984).

19. National Clearinghouse on Child Abuse and Neglect Information, *State Statutes Related to Child Abuse and Neglect*, 1988.

20. K.C. Faller, *Understanding Child Sexual Maltreatment* (Newbury Park, CA: Sage, 1990).

21. *Ibid.*

22. K.C. Faller, "The Spectrum of Sexual Abuse in Daycare: An Exploratory Study," *Journal of Family Violence* 3(1988):283–398.

23. D. Campagna and D. Poffenberger, *Sexual Trafficking in Children* (Dover, MA: Auburn House, 1988).

24. *Child Abuse and Neglect*, Vol. 15, No. 3 (1991).

25. Russell, "The Incidence and Prevalence of Intrafamilial and Extrafamilial Sexual Abuse of Female Children."

26. D. Finkelhor et al., eds., *Sourcebook on Child Sexual Abuse* (Newbury Park, CA: Sage, 1986).

27. Russell, "The Incidence and Prevalence of Intrafamilial and Extrafamilial Sexual Abuse of Female Children."

28. Wyatt, "The Sexual Abuse of Afro-American and White Women in Childhood."

29. Finkelhor, *Sourcebook on Child Sexual Abuse*.

30. Faller, *Understanding Child Sexual Maltreatment*.

31. D. Finkelhor, *Child Sexual Abuse: New Theory and Research* (New York: The Free Press, 1984).

32. American Association for Protecting Children, *Highlights of Official Child Neglect and Abuse Reporting*, 1986.

33. U.S. Department of Health and Human Services, *Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988* (Washington, DC: U.S. Government Printing Office, 1988).

34. *Ibid.*

35. F. Porter, L. Blick, and S. Sgroi, "Treatment of the Sexually Abused Child," in S. Sgroi, ed., *Handbook of Clinical Intervention in Child Sexual Abuse* (Lexington, MA: Lexington Books, 1982), 109–146.

36. D. Finkelhor, "What's Wrong With Sex Between Adults and Children," *American Journal of Orthopsychiatry* 49(1979):692–697.

37. D. Finkelhor and A. Browne, "The Effects of Sexual Abuse," in D. Finkelhor et al., eds., *Sourcebook on Child Sexual Abuse* (Newbury Park, CA: Sage, 1986).

38. B. Steele and H. Alexander, "Long-Term Effects of Sexual Abuse in Childhood," in P.B. Mrazek and C.H. Kempe, *Sexually Abused Children and Their Families* (London: Pergamon Press, 1982).

39. J. Haugaard and N. Reppucci, *The Sexual Abuse of Children* (San Francisco: Jossey Bass, 1988).

40. J. Briere and M. Runtz, "Post Sexual Abuse Trauma," in G. Wyatt and G. Powell, eds., *Lasting Effects of Child Sexual Abuse* (Newbury Park, CA: Sage, 1988).

41. K. Kendall-Tackett, L.M. Williams, and D. Finkelhor, "The Impact of Sexual Abuse on Children: A Review of Recent Empirical Studies," Paper presented at the meetings of the American Professional Society on the Abuse of Children, January 1991, San Diego.

42. .Finkelhor et al., *Sourcebook on Child Sexual Abuse*.

43. Sgroi, *Handbook on Clinical Intervention in Child Sexual Abuse*.

44. J. Conte and J. Schuerman, "The Effects of Sexual Abuse on Children: A Multidimensional View," in G. Wyatt and G. Powell, eds., *The Lasting Effects of Child Sexual Abuse* (Newbury Park, CA: Sage, 1988).

45. M. Steinberg and M. Westhof, "Behavioral Characteristics and Physical Findings: A Medical Perspective," in K.C. Faller, *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management, and Treatment* (New York: Columbia, 1988).

46. J. Smith, R. Benton, J. Moore, and D. Runyan, *Understanding the Medical Diagnosis of Child Maltreatment* (Denver: American Humane Association, 1989).

47. *Ibid.*

48. S.J. Emans, E. Woods, N. Flagg, and A. Freeman, "Genital Findings in Sexually Abused, Symptomatic and Asymptomatic Girls," *Pediatrics* 79(1987):778–785.

49. Steinberg and Westhoff, "Behavioral Characteristics and Physical Findings."

50. S. White, D. Ingram, and P. Lyna, "Vaginal Introital Diameter in the Evaluation of Sexual Abuse," *Child Abuse and Neglect* 13(1989):217–224.

51. A. Heger, "The Hymen and Anus Revisited," presentation given at the First North American Conference on Child Abuse and Neglect, Toronto, June 7, 1991.

52. D. Muram, "Child Sexual Abuse: Relationship Between Sexual Acts and Genital Findings," *Child Abuse and Neglect* 13(1989):211–216.

53. Emans et al., "Genital Findings in Sexually Abused, Symptomatic and Asymptomatic Girls."

54. C.J. Hobbs and J.M. Wynne, "Sexual Abuse of English Boys and Girls: The Importance of Anal Examination," *Child Abuse and Neglect* 13(1989):195–210.

55. J. McCann, J. Voris, M. Simon, and R. Wells, "Perianal Findings in Prepubertal Children Selected for Nonabuse: A Descriptive Study," *Child Abuse and Neglect* 13(1989):179–193.

56. Steinberg and Westhoff, "Behavioral Characteristics and Physical Findings."

57. McCann et al., "Perianal Findings in Prepubertal Children."

58. Hobbs and Wynne, "Sexual Abuse of English Boys and Girls."

59. McCann et al., "Perianal Findings in Prepubertal Children."

60. Steinberg and Westhoff, "Behavioral Characteristics and Physical Findings."

61. D. Corwin, "Early Diagnosis of Child Sexual Abuse: Diminishing the Lasting Effects," in G. Wyatt and G. Powell, eds., *The Lasting Effects of Child Sexual Abuse* (Newbury Park, CA: Sage, 1990).

62. Faller, *Understanding Child Sexual Maltreatment*.

63. Campagna and Poffenberger, *Sexual Trafficking in Children*.

64. K.C. Faller, *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management, and Treatment* (New York: Columbia University Press, 1988).

65. J. Myers, *Legal Issues In Child Abuse and Neglect* (Newbury Park, CA: Sage, 1990).

66. Faller, *Child Sexual Abuse*.

67. S. Sgroi, F. Porter, and L. Blick, "Validation of Child Sexual Abuse," in S. Sgroi, ed., *Handbook of Clinical Intervention in Child Sexual Abuse* (Lexington, MA: Lexington Books, 1982), 59–79.

68. Steinberg and Westhoff, "Behavioral Characteristics and Physical Findings."

69. Faller, K.C. "Possible Explanations for Child Sexual Abuse Allegations in Divorce," *American Journal of Orthopsychiatry* 61(1991):86–91.

70. D.P.H. Jones and A. Seig, "Child Sexual Abuse Allegations in Custody or Visitation Cases: A Report of 20 Cases," in B. Nicholson and J. Bulkley, eds., *Sexual Abuse Allegations in Custody and Visitation Cases* (Washington, DC: American Bar Association, 1988), 22–36.

71. N. Theonnes and P. Tjaden, "The Extent, Nature, and Validity of Sexual Abuse Allegations in Custody/Visitation Disputes," *Child Abuse and Neglect* 14(1990):151–163.

72. H. Giarretto, *An Integrated Approach to Child Sexual Abuse* (Palo Alto: Science and Behavior Books, 1982).

73. N. Groth, "Understanding Sexual Offense Behavior and Differentiating Among Sexual Abusers," in S. Sgroi, *Vulnerable Populations*, Vol. 2 (Lexington, MA: Lexington Books, 1989).

74. Faller, *Understanding Child Sexual Maltreatment*.

75. J. Myers, *Legal Issues in Child Abuse and Neglect* (Newbury Park, CA: Sage, 1992).

76. G. Goodman and A. Clark-Stewart, "Suggestibility of Children's Testimony: Implications for Sexual Abuse Investigations," in J. Doris, ed., *The Suggestibility of Children's Recollections* (Washington, DC: American Psychological Association, 1991).

77. A. Clarke-Stewart, W. Thompson, and S. Lepore, *Manipulating Children's Interpretations Through Interrogation*. Unpublished paper (Irvine, CA: University of California at Irvine, 1989).

78. J. Conte, E. Sorenson, L. Fogarty, and J. Dalla Rosa, "Evaluating Children's Reports of Sexual Abuse: Results From a Survey of Professionals," *American Journal of Orthopsychiatry* 61(1991):428–437.

79. A. Sivan, D. Schor, G. Koeppl, and L. Noble, "Interaction of Normal Children With Anatomical Dolls," *Child Abuse and Neglect* 12(1988):295–304.

80. M. Everson and B. Boat, "Sexualized Doll Play Among Young Children: Implications for the Use of Anatomical Dolls in Sexual Abuse Evaluations," *Journal of the American Academy of Child and Adolescent Psychiatry* 29(1990):736–742.

81. L. Jampole and K. Webber "An Assessment of the Behavior of Sexually Abused and Nonsexually Abused Children With Anatomically Correct Dolls," *Child Abuse and Neglect* 11(1987):187–192.

82. S. White, G. Strom, G. Santilli, and B. Halpin, "Interviewing Young Sexual Abuse Victims With Anatomically Correct Dolls," *Child Abuse and Neglect* 10(1986):519–30.

83. Everson and Boat, "Sexualized Doll Play Among Young Children."

84. M. Everson and B. Boat, "Putting the Anatomical Doll Controversy in Perspective: An Examination of the Major Uses and Related Criticism," *Child Abuse and Neglect*, in press.

85. N. Groth, *Anatomical Drawings* (Forensic Mental Health Associates, Inc., 1984).

86. A. Burgess, M. McCausland, and W. Wolbert, "Children's Drawings as Indicators of Sexual Trauma," *Perspectives in Psychiatric Care* 19(1981):50–58.

87. A. Yates, L Beutler, and M. Crago, "Drawings by Child Victims of Incest," *Child Abuse and Neglect* 9(1985):183–189.

88. Faller, *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management, and Treatment*.

89. G. Goodman, and R. Reed, "Age Differences in Eyewitness Testimony," *Law and Human Behavior* 10(1986):317–332.

90. K. Saywitz, G. Goodman, E. Nicholas, and S. Moan, *Children's Memories of Genital Exams: Implications for Cases of Child Sexual Assault*.

91. A. Yates, "Should Young Children Testify in Cases of Sexual Abuse?" *American Journal of Psychiatry* 144(4) (1987):476–79.

92. M. Steward, *Final Report of Grant #90CA1332 (NCAAN): The Development of a Model Interview for Young Child Victims of Sexual Abuse* (Davis, CA: Department of Psychiatry, University of California, 1989).

93. G. Goodman and C. Aman, "Children's Use of Anatomically Detailed Dolls To Recount an Event," *Child Development* 61(1990):1859–1871.

94. K. Saywitz, G. Goodman, and J. Myers, "Can Children Provide Accurate Eyewitness Accounts?" *Violence Update* 2(September 1990):10–11.

95. A. Clarke-Stewart, W. Thompson, and S. Lepore, *Manipulating Children's Interpretations Through Interrogation*.

96. Conte et al., "Evaluating Children's Reports of Sexual Abuse."

97. D. Corwin, "Early Diagnosis of Child Sexual Abuse: Diminishing the Lasting Effects," in G. Wyatt and G. Powell, eds., *The Lasting Effects of Child Sexual Abuse* (Newbury Park, CA: Sage, 1988).

98. M. De Young, "A Conceptual Model for Judging the Truthfulness of a Young Child's Allegation of Sexual Abuse," *American Journal of Orthopsychiatry* 56(1986):550–559.

99. K.C. Faller, "Is the Child Victim of Sexual Abuse Telling the Truth?" *Child Abuse and Neglect* 8(1984):473–481.

100. D. Jones and M. McQuiston, *Interviewing the Sexually Abused Child* (1986).

101. D. Jones and E.M. McGraw, "Reliable and Fictitious Accounts of Sexual Abuse to Children," *Journal of Interpersonal Violence* 2(1987):27–45.

102. H. Klajner-Diamond, W. Wehrspann, P. Steinhauer, "Assessing the Credibility of Young Children's Allegations of Sexual Abuse: Clinical Issues," *Canadian Journal of Psychiatry* 32(1987):610–614.

103. F. Sink, "A Hierarchical Model for Evaluation of Child Sexual Abuse," *American Journal of Orthopsychiatry* 58(1988):129–135.

104. J. Yuille, "The Systematic Assessment of Children's Testimony," *Canadian Psychology* 29(1988):247–259.

105. Faller, "The Spectrum of Sexual Abuse in Daycare: An Exploratory Study."

106. *Ibid.*

107. Sorenson and Snow, 1991.

108. W. Terry, "Perpetrator and Victim Accounts of Sexual Abuse," paper given at the Health Sciences Response to Child Maltreatment, San Diego, Center for Child Protection, 1991.

109. Jones and McGraw, "Reliable and Fictitious Accounts of Sexual Abuse to Children."

110. K.C. Faller, "Decision-Making in Cases of Intrafamilial Child Sexual Abuse," *American Journal of Orthopsychiatry* 1(1987):121–128.

111. P. Marchotka, F. Pittman, and K. Flomenhaft, "Incest as a Family Affair," *Family Process* 6(1967):98–116.

112. G. Abel, J. Becker, M. Mittelman, and J. Cunningham-Rather, *The Self-Reported Molestations of Non-Incarcerated Child Molester*, presented at the NIMH meeting on Assessment and Treatment of Sex Offenders, Tampa, FL, February 1986.

113. D. Finkelhor, *Child Sexual Abuse: New Theory and Research* (New York: The Free Press, 1984), 53–58.

114. Finkelhor et al., *Sourcebook on Child Sexual Abuse*, 89–142.

115. Faller, *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management, and Treatment*, 89–115.

116. Faller, *Understanding Child Sexual Maltreatment*, 54–65.

117. Porter, Blick, and Sgroi, "Treatment of the Sexually Abused Child," 112.

118. J.R. Wheeler and L. Berliner, "Treating the Effects of Sexual Abuse on Children," in G. Wyatt and G. Powell, eds., *The Lasting Effects of Child Sexual Abuse* (Newbury Park, CA: Sage, 1988), 227–249.

119. D. Finkelhor, "Sexual Abuse of Boys," in D. Finkelhor, *Child Sexual Abuse: New Concepts and Research* (New York: The Free Press, 1984).

120. Finkelhor et al., *Sourcebook on Child Sexual Abuse*, 102–104.

121. J. Briere and M. Runtz, "University Males' Sexual Interest in Children: Potential Indices of 'Pedophilia' in a Non-Forensic Sample," *Child Abuse and Neglect* 13(1988):65–76.

122. B. Maletzky, *Treating the Sexual Offender* (Newbury Park, CA: Sage, 1991).

123. *Ibid.*; W.L. Marshall, D.R. Laws, and H.E. Barbaree, eds., *Handbook of Sexual Assault* (New York: Plenum, 1990).

124. D.R. Laws, *Relapse Prevention in Sex Offenders* (New York, Guilford Press, 1989).

SELECTED BIBLIOGRAPHY

GENERAL OVERVIEWS

Bagley, C. R., and Thomlison, R. J., eds. *Child Sexual Abuse. Critical Perspectives on Prevention, Intervention, and Treatment*. Middletown, OH: Wall and Emerson, Inc., 1991.

American Academy of Pediatrics. "Guidelines for the Evaluation of Sexual Abuse of Children." *Pediatrics* 87(February 1991):254–260.

American Medical Association. *Diagnostic and Treatment Guidelines on Child Sexual Abuse*. Chicago: American Medical Association, 1992.

Goldman, R. L., and Gargiulo, R. M., eds. *Children at Risk. An Interdisciplinary Approach to Child Abuse and Neglect*. Austin, TX: Pro-ed, Inc., 1990.

O'Donohue, W., and Geer, J. H., eds. *The Sexual Abuse of Children: Theory and Research*. Vol. 1. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc., 1992.

O'Donohue, W., and Geer, J. H., eds. *The Sexual Abuse of Children: Clinical Issues*. Vol. 2. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc., 1992.

Sgroi, S. M., ed. *Vulnerable Populations. Evaluation and Treatment of Sexually Abused Children and Adult Survivors*. Vol. 1. Lexington, MA: Lexington Books, 1988.

Walker, L. E. A., ed. *Handbook on Sexual Abuse of Children. Assessment and Treatment Issues*. New York: Springer Publishing Company, 1988.

IDENTIFICATION AND INVESTIGATION

Chadwick, D. L.; Berkowitz, D. D.; Kerns, D.; McCann, J.; et al. *Color Atlas of Child Sexual Abuse*. St. Louis: Mosby-Year Book, Inc., 1989.

Child Abuse and Neglect. *Child Abuse and Neglect* 17(Special Issue 1993):3–185.

Giardino, A. P.; Finkel, M. A.; Giardino, E. R.; Seidl, T.; et al. *A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child*. Newbury Park, CA: Sage, 1992.

Horowitz, A. N. *The Clinical Detective. Techniques in the Evaluation of Sexual Abuse*. New York: Norton, 1992.

Krugman, R. D. "Physical Indicators of Child Sexual Abuse." In *American Psychiatric Press Review of Psychiatry*, edited by A. Tasman and S. M. Goldfinger, vol. 10. Washington, DC: American Psychiatric Press, Inc., 1991.

McGovern, K. B. "The Assessment of Sexual Offenders." In *Treating the Sexual Offender*, edited by B. M. Maletsky. Newbury Park, CA: Sage, 1991.

Schene, P., and Bond, K., eds. *Research Issues in Risk Assessment for Child Protection*. Denver: American Association for Protecting Children, 1989.

INTERVIEWING TECHNIQUES

Greenberg, S. A. "Conducting Unbiased Sexual Abuse Evaluations. Some Suggestions for Conducting Interviews of Sex Abuse Victims." *Preventing Sexual Abuse* 2(Summer 1990):8–14.

Maan, C. "Assessment of Sexually Abused Children With Anatomically Detailed Dolls: A Critical Review." *Behavioral Sciences and the Law* 9(Winter 1991):43–51.

Quinn, K. M., and White, S. "Interviewing Children for Suspected Sexual Abuse." In *Clinical Handbook of Child Psychiatry and the Law*, edited by D. H. Schetky and E. P. Benedek. Baltimore: Williams and Wilkins, 1992.

Vizard, E. "Interviewing Children Suspected of Being Sexually Abused: A Review of Theory and Practice." In *Clinical Approaches to Sex Offenders and Their Victims*, edited C. R. Hollin and K. Howells. Wiley Series in Clinical Approaches to Criminal Behavior. West Sussex, England: John Wiley and Sons, Ltd., 1991.

Whitcomb, D. *When the Victim Is a Child*. Issues and Practices in Criminal Justice. Cambridge, MA: Abt Associates Inc., 1992.

RELIABILITY AND SUGGESTIBILITY OF CHILD WITNESSES

Doris, J., ed. *The Suggestibility of Children's Recollections*. Washington, DC: American Psychological Association, 1991.

Goodman, G. S., and Bottoms, B. L. *Child Victims, Child Witnesses. Understanding and Improving Testimony*. New York: Guilford Press, 1993.

Saywitz, K. J.; Goodman, G. S.; and Myers, J. E. B. "Can Children Provide Accurate Eyewitness Reports?" *Violence Update* (September 1990):1, 4, 10–11.

TREATMENT ISSUES

Dickstein, L. J.; Hinz, L. D.; and Eth, S. "Treatment of Sexually Abused Children and Adolescents." In *American Psychiatric Press Review of Psychiatry*, edited by A. Tasman and S. M. Goldfinger, vol. 10. Washington, DC: American Psychiatric Press, Inc., 1991.

Friedrich, W. N. *Psychotherapy of Sexually Abused Children and Their Families*. New York: Norton, 1990.

Friedrich, W. N., ed. *Casebook of Sexual Abuse Treatment*. New York: Norton, 1991.

Mandell, J. G.; Damon, L.; Castaldo, P. C.; Tauber, E. S.; et al. *Group Treatment for Sexually Abused Children*. New York: Guilford Press, 1989.

Salter, A. C. *Treating Child Sex Offenders and Victims: A Practical Guide*. Newbury Park, CA: Sage, 1988.

Sgroi, S. M. *Vulnerable Populations. Sexual Abuse Treatment for Children, Adult Survivors, Offenders, and Persons With Mental Retardation*. Vol. 2. Lexington, MA: D. C. Heath, 1989.

Solnit, A. J.; Nordhaus, B. R.; and Lord, R. *When Home Is No Haven. Child Placement Issues*. New Haven: Yale University Press, 1992.

OTHER RESOURCES

ACTION for Child Protection
4724 Park Road
Unit C
Charlotte, NC 28203
(704) 529–1080

American Professional Society on the Abuse of Children (APSAC)
University of Chicago
School of Social Service Administration
969 East 60th Street
Chicago, IL 60637
(312) 702–9419

Association for Sexual Abuse Prevention (ASAP)
P.O. Box 421
Kalamazoo, MI 49005
(616) 349–9072
(216) 221–6818

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
University of Colorado Health Services Center
Department of Pediatrics
1205 Oneida Street
Denver, CO 80220
(303) 321–3963

Child Welfare League of America (CWLA)
440 First Street, N.E.
Suite 310
Washington, DC 20001
(202) 638–2952

Childhelp USA
6463 Independence Avenue
Woodland Hills, CA 91367
(800)4–A–CHILD or
(800)422-4453

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
(703) 385–7565

Community Leadership to End Abuse of Children (CLEAC)
2211 Riverside Drive
Suite 14
Ottawa, Ontario, Canada
K1H 7X5
(613) 738–0200

Military Family Resource Center (MFRC)
Ballston Centre Tower Three
Ninth Floor
4015 Wilson Boulevard
Arlington, VA 22203
(703) 385–7567

National Association for the Prevention of Child Abuse and Neglect (NAPCAN)
P.O. Box C302
Clarence Street
Sydney, NSW, Australia 2000
(02) 233–3536

National Center for the Prosecution of Child Abuse
1033 North Fairfax Street
Suite 200
Alexandria, VA 22314
(703) 739–0321

National Center on Child Abuse and Neglect (NCCAN)
Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services
P.O. Box 1182
Washington, DC 20013
(703) 385–7565

National Child Abuse Coalition
733 15th Street, N.W.
Suite 938
Washington, DC 20005
(202) 347–3666

National Children's Advocacy Center
106 Lincoln Street
Huntsville, AL 35801
(205) 532–3460

National Committee for Prevention of Child Abuse and Family Violence
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
(312) 663–3520

National Council on Child Abuse and Family Violence
6033 West Century Boulevard
Suite 400
Los Angeles, CA 90045
(818) 505–3422
(800) 222–2000

National Resource Center on Child Abuse and Neglect
American Humane Association
63 Inverness Drive, East
Englewood, CO 80122
(800) 227–5242
(303) 695–0811

APPENDIX A

Child Sexual Behavior Inventory

William Friedrich, Ph.D.

CHILD SEXUAL BEHAVIOR INVENTORY (Version 2)*

Please circle the number that tells how often your child has shown the following behaviors *recently or in the last 6 months.*

0 = Never 1 = Less than once per month 2 = 1–3 times per month 3 = At least once per week

1.	0	1	2	3	Stands too close to people
2.	0	1	2	3	Talks about wanting to be the opposite sex
3.	0	1	2	3	Touches private parts when in public places
4.	0	1	2	3	Masturbates with hand
5.	0	1	2	3	Draws sex parts when drawing pictures of people
6.	0	1	2	3	Touches or tries to touch mother's or other women's breasts
7.	0	1	2	3	Masturbates with object
8.	0	1	2	3	Touches other people's private parts
9.	0	1	2	3	Imitates the act of sexual intercourse
10.	0	1	2	3	Puts mouth on another child's or adult's sex parts
11.	0	1	2	3	Touches private parts when at home
12.	0	1	2	3	Uses words that describe sex acts
13.	0	1	2	3	Touches animals' sexual parts
14.	0	1	2	3	Makes sexual sounds (sighing, moaning, heavy breathing, etc.)
15.	0	1	2	3	Asks others to engage in sexual acts with her/him
16.	0	1	2	3	Rubs body against people or furniture
17.	0	1	2	3	Inserts or tries to insert objects in vagina or anus
18.	0	1	2	3	Tries to look at people when they are nude or undressing
19.	0	1	2	3	Imitates sexual behavior with dolls or stuffed animals
20.	0	1	2	3	Shows private parts to adults

* William Friedrich, Ph.D., Mayo Clinic, Rochester, MN.

21.	0	1	2	3	Tries to look at pictures of nude or partially dressed people (may include catalogs)
22.	0	1	2	3	Talks about sexual acts
23.	0	1	2	3	Kisses adults they do not know well
24.	0	1	2	3	Gets upset by public displays of affection
25.	0	1	2	3	Overly friendly with men they do not know well
26.	0	1	2	3	Kisses other children they do not know well
27.	0	1	2	3	Talks in a flirtatious manner
28.	0	1	2	3	Tries to undress other children or adults against their will (opening pants, shirt, etc.)
29.	0	1	2	3	Asks to look at nude or sexually explicit TV shows (may include videos or HBO-type shows)
30.	0	1	2	3	When kissing, tries to put tongue in other person's mouth
31.	0	1	2	3	Hugs adults they do not know well
32.	0	1	2	3	Shows private parts to children
33.	0	1	2	3	If a girl, overly aggressive; if a boy, overly passive
34.	0	1	2	3	Seems very interested in opposite sex
35.	0	1	2	3	Tries to put mouth on mother's or other women's breasts
36.	0	1	2	3	Other sexual behaviors (please describe)

A. _____

_____

B. _____

_____

APPENDIX B

Risk Assessment Protocol For Child Sexual Abuse

Kathleen Coulborn Faller, Ph.D.

RISK ASSESSMENT PROTOCOL FOR CHILD SEXUAL ABUSE

Family name _____ **Case number** _____

Victims _____

Offenders _____ **Date** _____

I. TYPE OF SEXUAL ABUSE

1. Sexual Talk

Comments: _____

_____

2. Exposure/Voyeurism

Comments: _____

_____

3. Fondle Outside Clothing

Comments: _____

_____

4. Fondle Under Clothing/Digital

Comments: _____

_____

5. Oral Sex/Genital/Anal Penetration

Comments: _____

_____

6. Pornography/Prostitution/Exploitation

Comments: _____

_____

II. CHARACTERISTICS OF THE ABUSE SITUATION

A. Duration

1. Short = 1 month

Comments: _____

_____

2. **Long = more than 1 month**

Comments: _____

_____

B. Number of Times

1. Few = 5 or fewer
2. Many = more than 5

Coments: _____

_____

C. Use of Force (absent versus present)

1. No force
2. Force

Comments: _____

_____

D. Threats Regarding Disclosure

0. No threats
1. Mild threats
2. Severe threats

Comments: _____

_____

III. VICTIM AGE

1. 14–16 years
2. 11–13 years
3. 8–10 years
4. 5–7 years
5. 3–4 years
6. 0–2 years

Comments: _____

_____

VI. SUSPECT–VICTIM RELATIONSHIP

1. Out-of-house, unrelated
2. Out-of-house, related
3. In-house child/teen
4. In-house unrelated male, unrelated female
5. In-house uncle, grandfather, aunt, grandmother, cousin
6. In-house father, stepfather, adoptive father, foster father
7. In-house mother, stepmother, adoptive mother, foster mother

Comments: _____

_____

V. NUMBER OF VICTIMS

Comments: _____

_____

VI. NUMBER OF PERPETRATORS

Comments: _____

_____

VII. FUNCTIONING OF THE NON-OFFENDING PARENT

A. Reaction to Knowledge About the Sex Abuse

0. Supportive of victim
1. Equivocal or inconsistent reaction
2. Supportive of suspect

Comments: _____

_____

B. Relationship to Victim

0. Close, nurturing relationship
1. Somewhat problematic relationship
2. Seriously problematic relationship

Comments: _____

_____

C. Level of Dependency (on suspect)

0. Very independent of suspect
1. Somewhat dependent on suspect
2. Very dependent on suspect

Comments: _____

_____

VIII. RESPONSE OF SUSPECT

1. Admits and takes responsibility
2. Admits but does not accept responsibility
3. Denies
4. Denies and blames victim

Comments: _____

_____

IX. OTHER INDIVIDUAL AND FAMILY PROBLEMS

A. Substance Abuse

0. No substance abuse
1. Substance use in the environment
2. Substance use by nonoffending parent
3. Substance use by suspect
4. Severe addiction of the suspect
5. Victim given chemicals during abuse

Comments: _____

_____

B. Violence

0. No violence in household
1. Suspect violent outside home
2. Suspect violent to nonoffending parent
3. Violence against child by nonoffending parent
4. Suspect violent to victim

Comments: _____

_____

C. Mental Retardation

0. No mental retardation in family
1. Nonoffending parent mentally retarded
2. Victim mentally retarded
3. Suspect mentally retarded

Comments: _____

_____

D. Mental Illness

0. No mental illness
1. Victim emotionally disturbed
2. Nonoffending parent mentally ill
3. Suspect mentally ill

Comments: _____

_____

E. Physical Handicaps (completely or partially blind, deaf, amputee, spinal bifida, wheelchair bound)

0. None in household
1. Victim physically handicapped
2. Nonoffending parent physically handicapped

Comments: _____

_____

APPENDIX C

A Continuum of Types of Questions
To Be Used in Interviewing Children
Alleged To Have Been Sexually Abused

Kathleen Coulborn Faller, Ph.D.

A Continuum of Types of Questions To Be Used in Interviewing Children Alleged To Have Been Sexually Abused

Kathleen Coulborn Faller, M.S.W., Ph.D

	Question Type	Example	Child Response	
Open-Ended	A. General*	Do you know why you came to see me today?	To tell you about my daddy.	**More Confidence**
	B. Focused	How do you get along with your dad?	OK, except when he babysits for me.	
		What happens when he babysits?	He plays a game with my hole.	
		What does he use to play with your hole?	His "wiener."	
	C. Multiple Choice	Does he play with your hole with his finger, his "wiener," or something?	He used his "wiener."	
		Did he say anything about telling or not telling?	Don't tell or you'll get punished.	
		Did you have your clothes off or on, or some off and some on?	I took my pants off.	
	D. Yes-No Questions	Did he tell you not to tell?	Yup.	
		Did you have your clothes off?	No, just my panties.	
	E. Leading Questions**	He took your clothes off, didn't he?	Yup.	
		Didn't he stick his "wiener" in your hole?	Yup.	
Close-Ended				**Less Confidence**

*Children usually are not very responsive to general questions.
**Not appropriate when interviewing children.

601

APPENDIX D

Guidelines for Determining the Likelihood Child Sexual Abuse Occurred

Kathleen Coulborn Faller, Ph.D.

Guidelines for Determining the Likelihood Child Sexual Abuse Occurred

Child's name _____ **Date**_____

I. THE CHILD'S ABILITY TO DESCRIBE (either verbally or behaviorally) THE SEXUAL BEHAVIOR.

A. Sexual knowledge beyond what would be expected for the child's developmental stage. Y N

Comments: _____

_____

B. Sexual behavior described from a child's viewpoint. Y N

Comments: _____

_____

C. Explicit accounts of sexual acts. Y N

Comments: _____

_____

II. THE CHILD'S ABILITY TO DESCRIBE THE CONTEXT OF THE SEXUAL ABUSE.

A. Where it happened. Y N NA*

Comments: _____

_____

B. When it happened. Y N NA

Comments: _____

_____

C. What the alleged offender said to obtain the child's involvement. Y N NA

Comments: _____

_____

D. Where other family members were. Y N NA

Comments: _____

_____

* not asked

E. What the victim was wearing. Y N NA

Comments: _____

_____

F. What clothing of victim was removed. Y N NA

Comments: _____

_____

G. What the alleged offender was wearing. Y N NA

Comments: _____

_____

H. What clothing of alleged offender was removed. Y N NA

Comments: _____

_____

I. Whether the alleged offender said anything about telling or not telling. Y N NA

Comments: _____

_____

J. Whether the child told anyone. Y N NA

Comments: _____

_____

K. Reactions of persons child has told. Y N NA

Comments: _____

_____

L. Frequency and/or duration Y N NA

Comments: _____

_____

M. Other (specify) Y N NA

Comments: _____

_____

III. THE CHILD'S AFFECT WHEN RECOUNTING THE SEXUAL ABUSE

A. Reluctance to disclose. Y N

Comments: _____

B. Embarrassment. Y N

Comments: _____

_____

C. Anger. Y N

Comments: _____

_____

D. Anxiety. Y N

Comments: _____

_____

E. Disgust. Y N

Comments: _____

_____

F. Sexual arousal. Y N

Comments: _____

_____

G. Fear. Y N

Comments: _____

_____

H. Other (specify) _____

_____

IV. MEDICAL EVIDENCE Y N

Comments: _____

_____

V. CONFESSION OF THE ALLEGED OFFENDER

Comments: _____

_____

VI. PHYSICAL EVIDENCE Y N

Comments: _____

_____

VII. OTHER WITNESSES

A. Children Y N

Comments: _____

_____

B. Adults Y N

Comments: _____

_____

VIII. OTHER EVIDENCE (specify)

_____

_____

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 — 723-925/80532